County of Los Angeles
CHIEF EXECUTIVE OFFICE

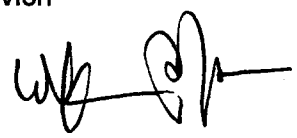
Kenneth Hahn Hall of Administration
500 West Temple Street, Room 713, Los Angeles, California 90012
(213) 974-1101
http://ceo.lacounty.gov

WILLIAM T FUJIOKA
Chief Executive Officer

November 9, 2010

To: Supervisor Gloria Molina, Chair
Supervisor Mark Ridley-Thomas
Supervisor Zev Yaroslavsky
Supervisor Don Knabe
Supervisor Michael D. Antonovich

From: William T Fujioka
Chief Executive Officer



LOS ANGELES COUNTY HOMELESS PREVENTION INITIATIVE STATUS REPORT

According to the Los Angeles Homeless Services Authority (LAHSA), Los Angeles County has the highest concentration of homelessness in the nation (50,000 people). Various social and economic factors, as well as gaps in available housing and social services, have contributed to the crisis.

On April 4, 2006, your Board approved the County Homeless Prevention Initiative (HPI) in response to this crisis. The HPI consisted of two categories of funding: (1) $15.4 million in funding for ongoing programs; and, (2) $80 million in one-time funding to develop innovative programs. Both funding categories are to focus on reducing or preventing homelessness. In approving the HPI, your Board directed the Chief Executive Office (CEO) to coordinate the preparation of quarterly status reports beginning in September 2006, providing your Board with implementation updates and analysis of results of the various HPI programs in reducing and preventing homelessness.

The CEO continues to implement specific key HPI programs in partnership with County Departments of Children and Family Services (DCFS), Health Services (DHS), Mental Health (DMH), Probation, Public Defender, Public Health (DPH), Public Social Services (DPSS), and the Sheriff, along with other agencies including the County's Community Development Commission, Los Angeles Homeless Service Agency, and various cities. Through June 2010, the HPI has been tremendously successful in implementing 32 programs and serving over 50,500 individuals and nearly 22,000 families (some programs may serve the same participants).

The initiative focuses on reaching the following two goals through the six strategies shown below:

Goal 1 – Preventing Homelessness
- Housing assistance
- Discharge planning (transitional supportive services)

Goal 2 – Reducing Homelessness
- Community capacity building
- Regional planning
- Supportive services integration linked to housing
- Innovative program design

Three attachments are included with this memo:

1. Executive Summary of Fiscal Year (FY) 2009-10, Fourth Quarter;

2. HPI Status Report (Attachment A): The FY 2009-10 Fourth Quarter HPI status report includes information on program participants, services provided, and associated outcomes; and

3. Index of Programs (Attachment B): The table presents key performance indicators and budget information on each program. Following the table, each program's performance measures are included with a description of successes, challenges, an action plan, and a client success story.

This HPI report provides information about the progress of your Board's investment to decrease homelessness and future planning efforts. If you have any questions, please contact Kathy House, Assistant Chief Executive Officer at (213) 974-4530, or via e-mail at khouse@ceo.lacounty.gov.

WTF:BC:KH
VKD:cvb

Attachments (3)

c: Executive Office, Board of Supervisors
County Counsel
Children and Family Services
Community Development Commission
Health Services
Mental Health
Probation
Public Defender
Public Health
Public Social Services
Sheriff
City of Santa Monica
Los Angeles Homeless Services Authority
Public Counsel
Skid Row Housing Trust

Los Angeles County
HOMELESS PREVENTION INITIATIVE (HPI)

FY 2009-10, APRIL – JUNE, FOURTH QUARTER EXECUTIVE SUMMARY

Above: The Access to Housing for Health participants receive certificates from staff at the program's graduation.

ACCESS TO HOUSING FOR HEALTH

The Access to Housing for Health (AHH) program is a partnership between the County Department of Health Services (DHS), Homeless Health Care Los Angeles (HHCLA), the Housing Authority of the County of Los Angeles (HACoLA), and the Housing Authority of the City of Los Angeles (HACLA). The program provides discharge planning for homeless hospital patients with chronic medical conditions. Participants are frequent users of the DHS hospital system and are eligible for Section 8 housing. Discharge planning offers medical care, mental health care, substance abuse treatment, and other supportive services to improve health outcomes and decrease costly inpatient and emergency room (ER) visits. In addition, AHH participants receive assistance with housing applications, housing location services, and case management to maintain permanent housing.

The AHH program has been funded through the HPI since 2006. As of June 2010, a total of 101 individuals had been permanently housed. Moreover, 148 connections were made to various public benefits, including Supplemental Security/Disability Income (SSI/SSDI), Medi-Cal, and General Relief (GR). Partners of the AHH program received a 2010 National Association of Counties (NACo) Achievement Award. Furthermore, Supervisor Don Knabe recognized the program's achievements. The following program outcomes demonstrate AHH's success in achieving housing stability, improved health outcomes, and cost avoidance –

- 95% of clients placed into permanent housing have retained housing for 12 months or more;
- 76% reduction in ER visits and an 85% reduction in inpatient days pre/post 12 months of housing; and
- $1.5 million in cost avoidance after 12 months based on a reduction in the number of AHH patients' ER visits and inpatient days.

While AHH shows promising results, staff no longer accept new referrals due to dwindling funds and a lack of available Section 8 vouchers that are needed to sustain the program. Clients and graduates continue to participate in monthly meetings that offer resources, health education, and a range of community-based services.

The HPI has served over 50,500 individuals and nearly 22,000 families. For each strategy, specific outcomes and a combined total of estimated actual expenditures are listed. For both the Housing Assistance and Supportive Services Integration and Linkages to Housing strategies, cumulative results are shown.

GOAL 1: PREVENTING HOMELESSNESS

HOUSING ASSISTANCE — $10,899,999

Eviction Prevention
Moving Assistance
Rental Subsidy

Through housing assistance, individuals, youth, and families maintain permanent housing.

- **6,550 individuals and 15,541 families received housing assistance, which prevented homelessness.**

Note: A participant who received more than one type of housing assistance was counted once.

DISCHARGE PLANNING — $11,191,401

Access to Housing for Health
Homeless Release Projects
Just In-Reach Program
Recuperative Care

Clients discharged from public hospitals and jails receive case management, housing location, and supportive services.

- **4,334 clients received public benefits.**
- **287 clients placed into permanent housing.**
- **85% decrease in inpatient days and 76% decrease in ER visits a year post enrollment.**

GOAL 2: REDUCING HOMELESSNESS

COMMUNITY CAPACITY BUILDING — $12,012,032

City and Community Program (CCP)
Revolving Loan Fund

Provide 21 communities with housing development and supportive services via contracts with local housing developers and service providers.

- **4,638 individuals and 970 families received 12,943 linkages to supportive services and 1,921 housing placements.**

REGIONAL PLANNING — $4,465,683

Homeless Services
Long Beach Homeless Veterans

Helping communities address homelessness in their neighborhoods through development of housing resources and service networks.

- **Gateway and San Gabriel Valley Council of Governments (COG) presented regional plans to include 1,253 units of permanent housing.**

SUPPORTIVE SERVICES INTEGRATION AND LINKAGES TO HOUSING — $16,551,215

Case Management
Housing Locators
Multi-disciplinary Team/Access Center

Provide clients with integrated supportive services and housing. Supportive services include case management, health care, mental health services, and substance abuse treatment.

- **15,768 individuals and 7,256 families placed into emergency, transitional, and permanent supportive housing.**
- **45,773 linkages to integrated supportive services enhanced participants' well-being.**
- **13,270 individuals and families achieved greater self-sufficiency through public benefits, income support, and connections to employment opportunities.**

INNOVATIVE PROGRAM DESIGN — $19,540,379

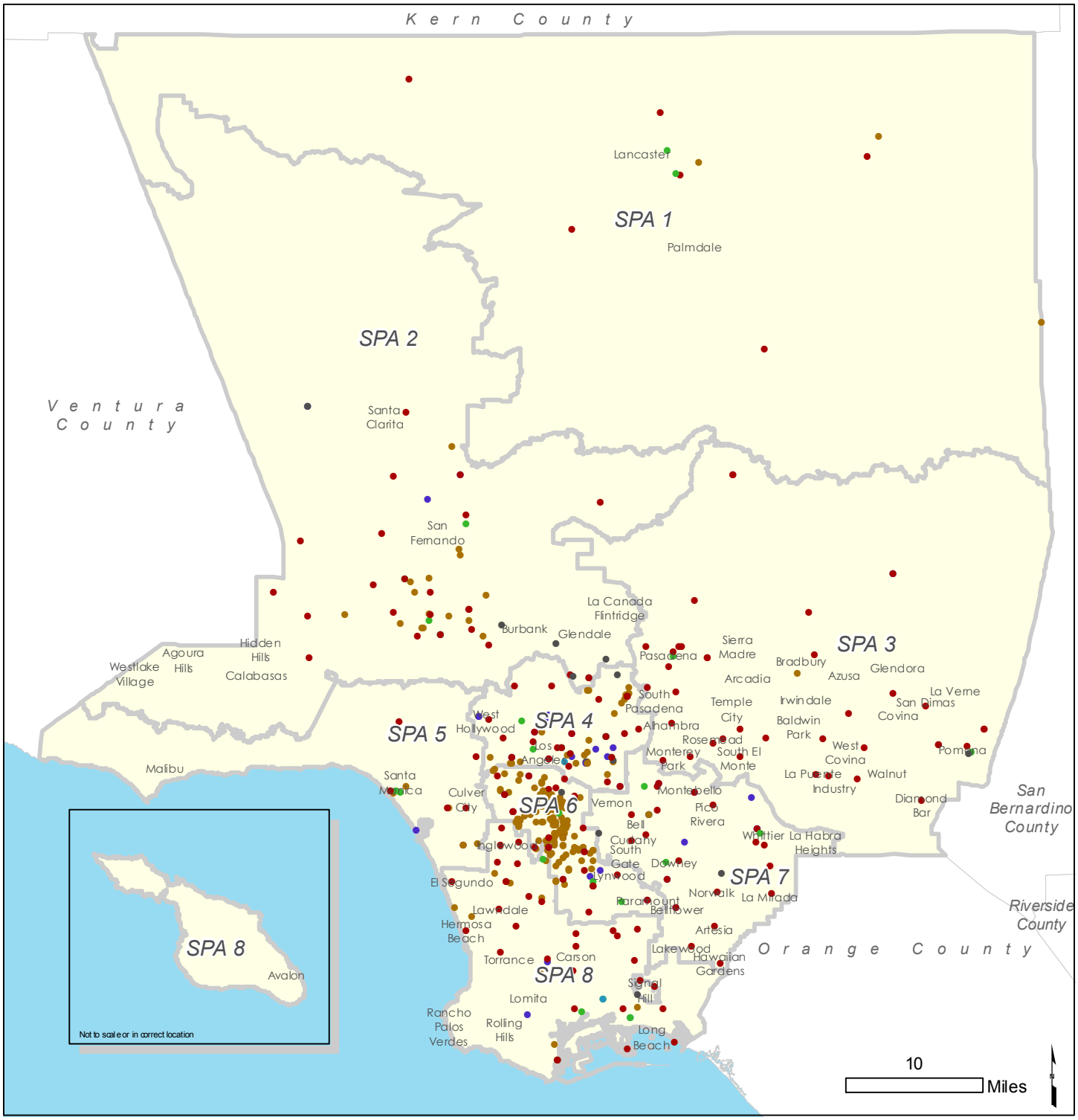
Project 50
Skid Row Families Demonstration Project
Homeless Court
Housing Resource Center
Santa Monica Service Registry

Provide access to housing and services for the most vulnerable, including chronic homeless individuals and families on Skid Row, individuals with co-occurring disorders, and homeless individuals with outstanding warrants.

- **146 chronic homeless individuals placed into permanent supportive housing.**
- **241 Skid Row families placed into permanent rental housing (93% retained at 12 months).**
- **Citations and warrants dismissed for 2,153 individuals.**
- **Over 5.3 million housing searches conducted.**

County of Los Angeles Regional Homeless Prevention Initiative

Housing Placement and Service Locations by Service Planning Area (SPA)



Strategy

- 1 - Housing Assistance
- 2 - Transitional Supportive Services
- 3 - Community Capacity Building
- 4 - Regional Planning
- 5 - Supportive Services Integration and Linkages to Housing
- 6 - Innovative Program Design

Notes:

i) The following HPI programs are offered Countywide:
General Relief Housing Subsidy and Case Management Project
Los Angeles County Homeless Court
Los Angeles County Housing Resource Center
Moving Assistance for Single Adults in Emergency/Transitional Shelter or Similar Temporary Group Living Program
Project Homeless Connect

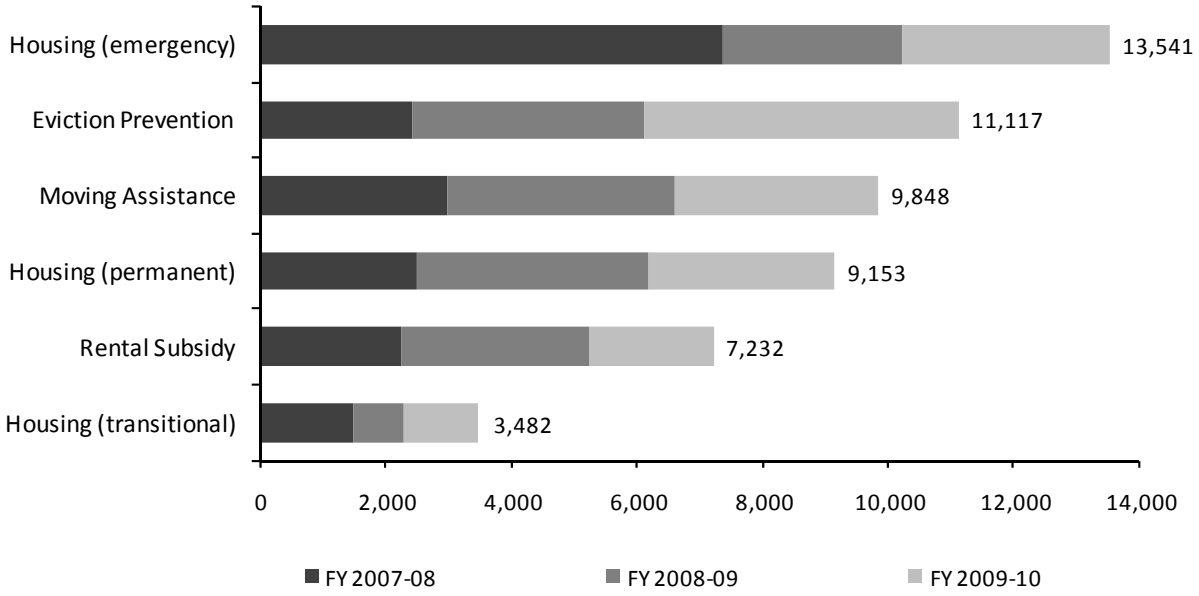
ii) Strategy 4 - Regional Planning includes San Gabriel Valley Council of Government Plan and Gateway Cities Homeless Strategy.

iii) Rental subsidies were provided to transition age youth who moved to cities in other counties, including: San Bernardino, Riverside, Kern, Orange, San Diego, Ventura, and Santa Barbara.

Map created by ISD/UR-GIS YM (562-940-2181) on 2009-05-14, HPI.mxd
Data from CEO/SIB, LACoeGIS Repository, and Thomas Bros Data.

It is the County's goal to work with community partners to further reduce and prevent homelessness. The chart below shows the number of HPI participants who received housing and financial assistance through June 2010.

HPI Participants Receiving Housing/Housing Assistance



Information about the County of Los Angeles Homeless Prevention Initiative

The Los Angeles County Board of Supervisors invested resources to address and prevent homelessness with the approval of the $100 million Homeless Prevention Initiative (HPI). The Chief Executive Office (CEO) continues to implement specific key HPI programs in partnership with County departments, the Los Angeles Homeless Services Authority (LAHSA), Community Development Commission (CDC), and various cities. To date, the HPI has been tremendously successful in implementing 32 programs and serving over 50,500 individuals and nearly 22,000 families. The initiative focuses on reaching the following two goals through six strategies shown below:

Goal	Strategy
Preventing Homelessness	• Housing assistance • Discharge planning (transitional supports)
Reducing Homelessness	• Community capacity building • Regional planning • Supportive services integration and linkages to housing • Innovative program design

For additional information, please contact Vani Dandillaya at vdandillaya@ceo.lacounty.gov.

COUNTY OF LOS ANGELES

Homeless Prevention Initiative (HPI)
FY 2009-10, Fourth Quarter Status Report

TABLE OF CONTENTS

Following the **Executive Summary** of this report are two attachments.

Attachment A: Overview of HPI Status

Attachment B: Index of HPI Programs by Population *(Table on page 1)*

HOMELESS PREVENTION INITIATIVE (HPI) STATUS REPORT
FY 2009-10, Fourth Quarter

I. INTRODUCTION

In accordance with your Board's direction on April 4, 2006, this report provides a status update on the implementation of 32 programs included in the Los Angeles County Homeless Prevention Initiative (HPI) during April-June of FY 2009-10. The Chief Executive Office (CEO) continues to implement specific key HPI programs in participation with the Community Development Commission (CDC), the Departments of Children and Family Services (DCFS), Health Services (DHS), Public Health (DPH), Mental Health (DMH), Public Social Services (DPSS), Probation, Public Defender, and the Sheriff. Representatives from these County agencies, departments, and several partner organizations meet frequently to ensure consistent communication and integration of services and facilitate successful implementation of HPI programs serving the County's homeless population.

HPI funding has allowed for greater access to housing and supportive services for the homeless and at-risk population. This HPI status update highlights results achieved through program strategies that have served over 50,500 individuals and 21,900 families.[1] This report features components of the HPI, associated outcomes, and opportunities to strengthen County homeless coordination.

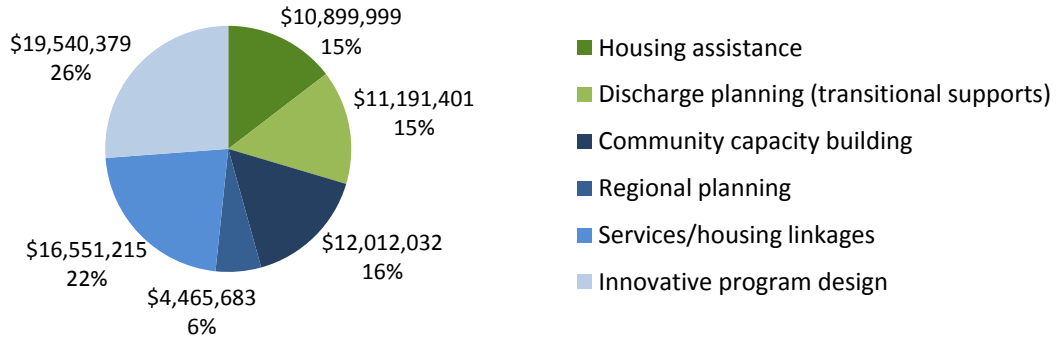
Goals and Strategies

As mentioned in the Executive Summary, the CEO continues to implement specific key HPI programs in partnership with County departments, the Los Angeles Homeless Services Authority (LAHSA), CDC, and various cities. The initiative focuses on meeting the following two goals through six strategies shown:

Goal	Strategy
Preventing Homelessness	• Housing assistance • Discharge planning (transitional supports)
Reducing Homelessness	• Community capacity building • Regional planning • Supportive services integration and linkages to housing • Innovative program design

[1] Currently, a standardized data system is not in place to determine if any client is shared across programs, therefore, the total number of participants may include a duplicate count.

Chart 1: Estimated Actual Expenditures
Total: $74,660,709*



*Estimated actual expenditures are approximately $78.6 million. Additional expenditures include: 1) Board approved operational support at $1.9 million (FY 2006-07); and 2) operational support, administrative, and evaluation costs at approximately $2.0 million. *From upper right (clockwise) beginning with Housing Assistance.*

Estimated Actual Expenditures by Strategy

In this report, total expenditures include FYs 2006-07, 2007-08, 2008-09 actual expenditures and FY 2009-10 estimated actual expenditures. The total estimated actual expenditures for the HPI programs in this report are $74.6 million. Chart I shows that 30 percent of all expenditures have been spent on the initiative's first goal to prevent homelessness. Seventy percent of all expenditures have been spent on the HPI's second goal to reduce homelessness. In addition, Chart I shows the amount expended by each strategy. For the community capacity building strategy, capital projects for housing development have been delayed due to the economic condition, therefore, the actual expenditures are significantly less than previously estimated for FYs 2008-09 and 2009-10. Through FY 2008-09, the greatest percentage (26 percent) of actual expenditures was spent on innovative programs, including *Housing First* models for chronically homeless participants.

The following sections of the HPI status report provide an overview of participants and the initiative's progress in preventing and reducing homelessness.

II. PARTICIPANTS

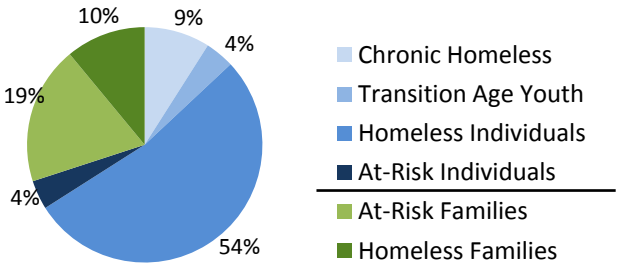
During the fourth quarter of FY 2009-10, 29 of 32 implemented HPI programs[2] directly served the County's homeless and nearly homeless. While several programs served more than one population, participants in 25 programs corresponded to one of five categories: homeless individuals (13 programs), chronic homeless individuals (four programs), transition age youth (two programs), homeless and at-risk families (six programs). Attachment B provides an overview of programs. To date, Table 1 shows HPI improved the lives of 50,524 individuals and 21,922 families.[3] During the fourth quarter, the number of families and individuals served increased by nine percent.

Table 1: Number of Contacts by Participant Category
FY 2009-10 through June 30, 2010

	FY 2009-10*	FY 2008-09*	FY 2007-08	Cumulative	Fourth Qtr. Increase
Homeless Individuals	17,932	8,722	12,206	38,860	10%
Chronic Homeless Individuals	1,772	2,181	2,443	6,396	6%
Transition Age Youth	441	1,100	1,122	2,663	3%
At-Risk Individuals	1,622	983	-	2,605	16%
Total for Individuals	21,767	12,986	15,771	50,524	9%
Homeless Families	1,774	1,860	3,950	7,583	3%
At-Risk Homeless Families	6,769	5,082	2,487	14,338	12%
Total for Families	8,543	6,942	6,437	21,922	9%
TOTAL	**30,310**	**19,928**	**22,208**	**72,446**	**9%**

*FYs 2008-09 and 2009-10: To calculate an unduplicated count within each program, returning participants were not included.

Chart 2: Percent by Participant Category



From upper right (clockwise) beginning with Chronic Homeless.

Chart 2 illustrates that of HPI participants, 70 percent were individuals and 30 percent were families. According to LAHSA, 12 percent of the total homeless population lives in families,[4] and similarly homeless families made up 10 percent of all HPI participants. Of all HPI participants, 54 percent were homeless adults, four percent were at-risk adults, and four percent were transition age youth. Approximately one-fourth of the homeless in the County are chronically homeless,[5] while these individuals made up nine percent of all participants.

[2] While Housing Locator and Housing Specialists programs are included, these programs are funded by CalWORKs Single Allocation and DMH Mental Health Services Act (MHSA), respectively. City and Community Program includes 21 separate programs. Project Homeless Connect participants are not included in the total as many are connected to other programs.
[3] Note most programs provided an unduplicated participant number; however, four programs included a duplicated participant count during FY 2007-08. Housing Locators/Housing Specialists are included in total participant count.
[4] LAHSA 2009 Greater Los Angeles Homeless Count.
[5] Ibid.

Participant Characteristics

During the third quarter, all 29 programs provided demographic information for program participants. Demographic information included gender, age, and race/ethnicity of participants. To obtain data on HPI participants, demographic information from new participants served during this past quarter was included. Gender information from LAHSA contracted programs was added. Due to different categorization for race/ethnicity and age, these statistics for LAHSA contracted programs are shown separately in Attachment B.

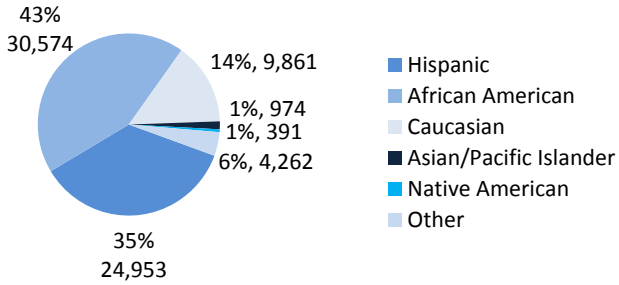
Gender

Approximately 67 percent of the homeless population in Los Angeles County consists of adult men.[6] Of the 75,817 participants whose gender was provided, 54 percent (41,132) were male and 46 percent (34,631) were female.

Race/Ethnicity

The total homeless population in Los Angeles County is 43 percent African American and 29 percent Hispanic/Latino. Chart 3 shows 43 percent of HPI participants were African American, 35 percent were Hispanic/Latino, and 14 percent Caucasian. The remaining eight percent of participants included Asian/Pacific Islander, Native American, and other racial/ethnic groups.

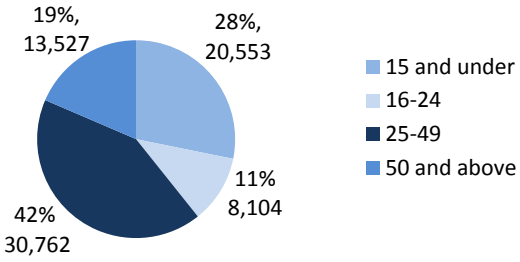
Chart 3: Race of HPI Participants (n=71,015)



Age

Of all HPI participants, a total of 42 percent was between 25-49 years of age. Chart 4 shows that of HPI participants whose age was provided, 28 percent were children 15 years of age or younger, 11 percent of participants were between the ages of 16-24, and 19 percent were 50 years of age and older.

Chart 4: Age of HPI Participants (n=72,946)



[6] LAHSA 2009 Greater Los Angeles Homeless Count.

III. GOALS, STRATEGIES, AND OUTCOMES

Goal I: Preventing Homelessness

Strategy 1 Housing Assistance $10,899,999

Through housing assistance, individuals, youth, and families maintain permanent housing.

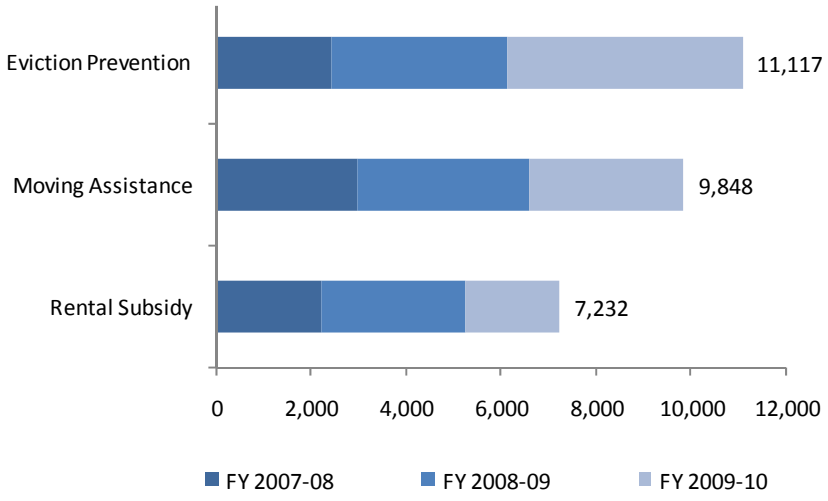
Eviction Prevention • Moving Assistance • Rental Subsidy

HPI programs provided housing assistance through moving assistance, eviction prevention, and rental subsidies; five programs focused on these services. ***Through June 2010, a total of 22,091 participants received housing assistance to secure permanent housing and prevent homelessness.*** A participant who received more than one type of housing assistance was counted once. Table 2 shows 70 percent of participants who obtained housing assistance were families, 25 percent were individuals, and five percent were transition age youth. Table 2 illustrates that a greater proportion of individuals and transition age youth received rental subsidies, whereas significantly more families obtained eviction prevention. Chart 5 shows the number of participants who received each type of housing assistance through June 2010.

Table 2: Through June 2010		**Housing Assistance**	**Moving Assistance**	**Rental Subsidy**	**Eviction Prevention**
Individuals	5,372	25%	3,661	5,647	131
Transition Age Youth	1,178	5%	606	1,056	2
Families	15,541	70%	5,464	390	10,841
Total participants	22,091	100%	9,731	7,093	10,981
Expenditures		**$10,899,999**	**$6,193,951**	**$902,274**	**$3,803,774**

The following participants were not included in Table 2: 117 participants who received moving assistance, 136 who received eviction prevention, and 139 who received rental subsidies.

Chart 5: Housing Assistance Provided to HPI Participants



Strategy 2 Discharge Planning (Transitional Supports) $11,191,401

Clients discharged from public hospitals and jails receive case management, housing location, and supportive services.

Access to Housing for Health (AHH) • Recuperative Care • Homeless Release Projects (DPSS-DHS and DPSS-Sheriff) • Just In-Reach Program (JIR)

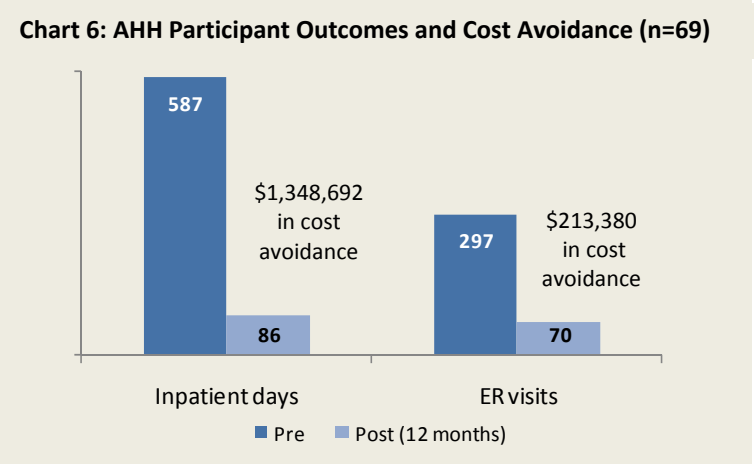
Discharge Planning for Hospital Patients

Access to Housing for Health (AHH), Recuperative Care, and DPSS-DHS Homeless Release programs provided discharge planning for hospital patients at-risk of becoming homeless. A discharge plan connected patients to services that helped them attain stable housing and a better quality of life. Both the AHH and Recuperative Care programs have shown improvements in health outcomes, such as reductions in Emergency Room (ER) visits and inpatient hospitalizations.

Outcomes

- ***Improved Health***: From March 2007 to March 2010, 69 AHH clients completed 12 months with a 76% decrease in ER visits and an 85% reduction in inpatient days.
- ***Cost Avoidance:*** After 12 months, a reduction in the number of AHH patients' ER visits and inpatient days resulted in the cost avoidance of over $1.5 million (Chart 6).
- ***Linkages to Public Benefits***: These programs made 672 connections to public benefits for individuals, including: Supplemental Security/Disability Income (SSI/SSDI), Medi-Cal, and General Relief (GR).
- ***Housing Stability***: As of June 2010, AHH placed 104 individuals into permanent housing, and 98 percent (82 individuals to date) have maintained permanent housing for six months or more.

Chart 6: AHH Participant Outcomes and Cost Avoidance (n=69)



Discharge Planning for Individuals Released from Jails

Just In-Reach (JIR) and DPSS-Sheriff Homeless Release projects connected individuals to services and benefits prior to release from jail to help support steps towards building a better future, including stable housing and employment.

Outcomes

- ***Linkages to Public Benefits***: The JIR and DPSS-Sheriff Homeless Release projects served 6,852 individuals and made 3,377 connections to such public benefits as: GR, Food Stamps, SSI/SSDI, and Veteran's benefits.
- ***Housing Placement***: Housing locators assisted 569 individuals with housing placement. Through the JIR program, 288 clients identified as homeless or chronically homeless have been released to housing, transitional living or a residential program.
- ***Transition to Communities:*** By offering case management to all JIR clients, 696 linkages have been made to job training/placement or education. The recidivism rate of JIR participants has been 34% over the past 21 months, which is considerably less than that of the general County Jail system population (53%).

Goal 2: Reducing Homelessness

Strategy ❸ Community Capacity Building $12,012,032

Provide 21 communities with housing development and supportive services via contracts with local housing developers and service providers.

City and Community Program (CCP) • Revolving Loan Fund

City and Community Program (CCP)

- Fifteen programs served 4,638 individuals and 970 families. The programs made ***12,934 linkages to supportive services and 1,921 housing placements***. Three permanent supportive housing programs showed an average housing retention rate of 88% percent at six months.
- The CDC has executed 15 service and three capital contracts are fully implemented. Four additional service contracts will be executed upon completion of the capital component of these projects. Programmatic and financial monitoring of service projects continued in April through June, with an additional 11 engagements completed through June 2010. Overall, a total of 35 percent of the funds associated with executed service contracts have been expended to date. At this point, construction began on the Hope Gardens Family Center- Sycamore Hall Remodel, which is estimated to be completed by February 2011. Two other construction projects, the Compton Vets Services Center and Mason Court began and are expected to be completed in early 2011.

Revolving Loan Fund (RLF)

The current lending environment has been a challenge for many affordable housing developers. Moreover, developers need to be able to access funds to pay off Los Angeles County Housing Innovation Fund (LACHIF) loans. During the last quarter, the LACHIF closed one loan for $3.7 million. Additionally, Citibank provided $20 million in Class A capital. LACHIF lenders and CDC staff continue to market the fund. Previously, the Hudson Oaks loan was made by Century Housing to Abode Communities. Hudson Oaks is located in the City of Pasadena and will provide 45 units of affordable senior housing.

Strategy ❹ Regional Planning $3,250,000

Helping communities address homelessness in their neighborhoods through development of housing resources and service networks.

Gateway Cities Council of Government (COG) • San Gabriel Valley COG • Long Beach Homeless Veterans

- The San Gabriel Valley Council's of Government (COG) and the Gateway Cities COG are in the process of beginning phase II of their respective initiatives. Phase II will consist of overseeing the implementation of each plan. The efforts will serve to create affordable permanent housing, interim housing, homeless services, and capacity building. The County's Chief Executive Office created funding agreements with the COGs and/or their contracted partner to support these efforts.
- Over the next five years, San Gabriel Valley COG's Regional Homeless Service Strategy includes an objective to create 588 units of permanent supportive housing, and PATH Partners' Gateway Cities Homeless Strategy plans to create 665 permanent supportive housing units (Attachment B, p. 67).
- Long Beach Homeless Veterans provide case management, child support reduction, mental health

care, and housing. The County CEO's Research and Evaluation Services' analysis suggested that the program offset $1.4 million in County services after one year.[7] During this quarter, Single Parents United N Kids (SPUNK) closed 14 child support cases for a total arrears savings of $261,341. The City of Long Beach continued outreach efforts to homeless veterans, including ongoing referrals to the Long Beach Veterans Affairs (VA) Healthcare System HUD-Veteran Affairs Supportive Housing (VASH) Voucher program.

Strategy 5 Supportive Services Integration and Linkages to Housing $16,551,215

Clients receive integrated supportive services and housing.

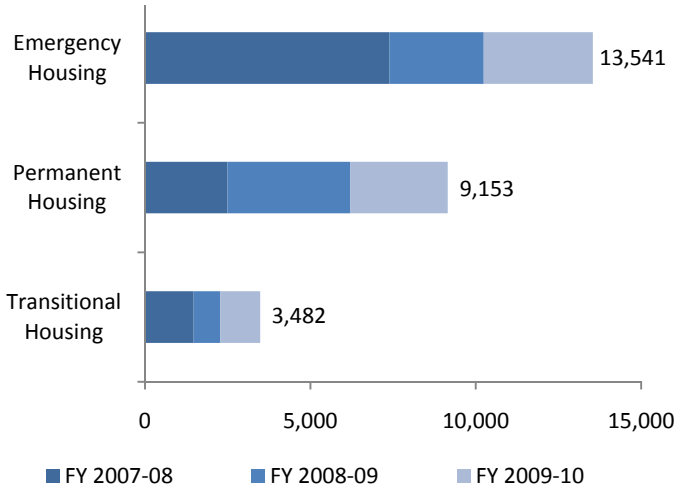
Case Management • Housing Locators • Multi-disciplinary Team/Access Center • Project Homeless Connect • Benefits Entitlement Services Team for the Homeless (B.E.S.T.)

Linkages to Housing – Chart 7 shows that a total of 9,153 households received permanent housing. Of the total categorized by population, Table 3 shows 62 percent were families, 10 percent transition age youth, and 28 percent individuals. In contrast, 84 percent of individuals received emergency/transitional housing placement. This quarter, 22 programs placed participants into temporary housing, and participants spent an average of 72 days in temporary housing prior to permanent or transitional housing.

Table 3: Housing Placement through June 2010	Emergency/ Transitional		Permanent Housing	
Individuals	12,162	84%	2,383	28%
Transition Age Youth	346	2%	877	10%
Families	2,011	14%	5,245	62%
Total	**14,519**	**100%**	**8,505**	**100%**

Services not categorized by population above: 648 who were moved into permanent housing; 1,560 who were moved into transitional housing; and 944 who were placed into emergency housing.

Chart 7: HPI Participants Moved into Housing



[7] Stevens M, et al. *Cost Avoidance Yielded Through Participation In The Long Beach Homeless Veterans Initiative*. County of Los Angeles, Chief Executive Office. Service Integration Branch, Research and Evaluation Services. March 2010.

Supportive Services Integration – Participants received supportive services in three categories: 1) employment/education, 2) benefits advocacy and enrollment assistance, and 3) health and human services.

Employment/Education Services and Support

Through June 2010, 22 HPI programs reported a total of 3,202 participants received job and/or education related supports (Table 4). Sixty percent of these participants received job training, referrals, or related resources. Participants in these programs included transition age youth, chronic homeless individuals and families on Skid Row, and participants with co-occurring disorders. As programs continue to make linkages to job and education related services and build infrastructure for data collection, these numbers have increased. By supporting the employable homeless to overcome barriers in obtaining and maintaining employment, more individuals have attained greater self-sufficiency.

Table 4: Jobs/Education	FY 2009-10	Cumulative*	Percent
Job training/referrals/resources	1,037	1,926	60%
Education (course, class, books)	271	658	21%
Job placement (employment)	320	618	19%
Total number of services provided:	**1,628**	**3,202**	**100%**

*Cumulative includes: FYs 2008-09 and 2009-10

Benefits Advocacy and Enrollment Assistance

For participants who entered programs in need of specific public benefits, 26 HPI programs reported enrolling homeless individuals and families. Table 5 shows that through June 2010, 5,907 homeless individuals were enrolled into General Relief, which consisted of 58 percent of all benefit enrollments. Twelve percent of participants were enrolled into Supplemental Security/Disability Income (SSI/SSDI), and seven percent received Medi-Cal/Medicare or Shelter Plus Care. Compared to enrollments from the previous quarter, SSI/SSDI and Food Stamps each increased the most with 15 percent more enrollments.

Table 5: Benefits	FY 2009-10	Cumulative*	Percent
General Relief (and Food Stamps)	1,565	5,082	50%
SSI/SSDI	655	1,202	12%
General Relief only	226	825	8%
Medi-Cal or Medicare	381	674	7%
Shelter Plus Care	304	666	7%
Food Stamps only	307	496	5%
Section 8	166	430	4%
CalWORKs	245	405	4%
Veterans	247	288	3%
Total number of benefits provided:	**4,106**	**10,068**	**100%**

*Cumulative includes: FYs 2008-09 and 2009-10

Supportive Health and Human Services

Through the fourth quarter of FY 2009-10, 29 programs made 45,773 linkages between participants and supportive health and human services. These programs served homeless and chronic homeless individuals, homeless families, and transition age youth. Table 6 shows 22 percent (10,542) of these HPI participants received case management, which was the most frequently reported supportive service. Followed by case management, 21 percent of linkages were for health care (9,737), and 16 percent (7,197) were for mental health care. Another 10 percent of these linkages connected participants to transportation services, including bus tokens and public transportation.

With 69 percent of the homeless population having a mental illness, substance abuse problem, or AIDS/HIV-related illness,[8] linking these individuals and families with health care, mental health care, and substance abuse services is critical. Additionally, with the Recovery Act's Homelessness Prevention and Rapid Re-Housing Program (HPRP) funds, the County has expanded services to assist families and individuals with credit repair, legal assistance, and money management. In a 2009 HPI survey, providers also indicated interest in improving access to child care, law enforcement, and employment support.

Twenty-five programs reported providing case management services, and 14 programs selected the most intense level of case management. The HPI Report Form asked about the level of case management provided, with level one assessing the client and level three assisting with supported referrals and counseling.[9] Hours provided to each participant per month ranged from 30 minutes to 341 hours (average of 36 hours) with an average caseload of 35 cases per case manager.

Table 6: Supportive Services	FYs 2008-09 and 2009-10	Percent	FY 2007-08*
Case management	10,542	22%	2,257
Health care	9,737	21%	183
Mental health care	7,197	16%	615
Transportation	4,501	10%	182
Life skills	3,723	8%	676
Alternative court	2,410	5%	286
Resident rights/responsibilities	1,931	4%	-
Social/community activity	1,372	3%	51
Food vouchers/food	1,431	3%	414
Substance abuse treatment	1,193	3%	130
Recuperative care	701	1%	45
Other**	477	1%	5
Clothing/hygiene	327	1%	80
Legal services	231	1%	15
Total number of services provided to participants:	**45,773**	**100%**	**4,939**

* For FY 2007-08, this report includes LAHSA contracted programs that provided referrals to mental health care (including domestic violence counseling) and substance abuse treatment.

**Other services include: auto insurance, driver's license release, identification card, and credit repair.

[8] LAHSA 2009 Greater Los Angeles Homeless Count.

[9] Post PA. *Developing Outcome Measures to Evaluate Health Care for the Homeless Services*. National Health Care for the Homeless Council. May 2005.

Strategy 6 Innovative Program Design $19,540,379

Provides access to housing and services for the most vulnerable, including chronic homeless individuals and families on Skid Row, individuals with co-occurring disorders, and homeless individuals with outstanding warrants.

Project 50 • Santa Monica Service Registry • Skid Row Families Demonstration Project • Homeless Courts • Housing Resource Center • Long Beach Housing Now

INNOVATIVE PROGRAM OUTCOMES

Housing First Models

- **Housing stability**: On average, *Housing First* models showed a successful 90 percent housing retention rate for individuals and families in permanent housing for six or more months. Housing First programs include: Project 50, Skid Row Families Demonstration Project, and the Santa Monica Service Registry.
- **Increased income**: After one year, Project 50 participants showed a 56 percent increase in benefits since enrollment.
- **Improvement in overall health and well-being**: At the end of one year, Project 50 participants spent significantly fewer days in ERs, hospitals, and jails with considerable cost savings for the County.

Homeless Courts

- **Pathways to self-sufficiency**: Eighty-five percent of Homeless Court participants had their warrants or citations dismissed, and they have been able to move forward by securing employment, reconnecting with their families, and planning for their future.

Los Angeles County Housing Resource Center (LACHRC)

- **Information sharing**: Over 5.3 million searches for housing listings have been conducted online. Nearly 8,000 landlords are registered on the website.

The HPI Report Form requested for programs to report on three outcome areas for participants receiving services for 6, 12 and 18 months. The three outcome areas were: 1) housing stability, 2) education and employment status, and 3) health and well-being. Seventeen programs that served chronic homeless individuals, transition age youth, and homeless individuals and families reported on these longer-term outcome areas.

Point in time outcomes for this past quarter at 6, 12, or 18 months post enrollment:

- **Housing stability**: A total of 2,169 participants continued to live in permanent housing and 1,587 continued to receive rental subsidies.
- **Employment/education**: A total of 141 participants obtained employment, 336 maintained employment, and 110 enrolled in an educational program.
- **Health and well-being**: The following number of participants continued to receive these services for six months or more: 2,413-case management; 2,785-health care; 876-mental health services; and 330-substance abuse treatment.

A brief description of each innovative program:

- **Project 50** – The project is a successful collaboration that includes over 24 government and non-profit agencies. Based on Common Ground's *Street to Home* strategy, Project 50 integrates housing and supportive services for vulnerable, chronic homeless individuals living near downtown Los Angeles on Skid Row. A year after its launch, the pilot successfully moved 50 vulnerable, chronic homeless individuals off of Skid Row with an impressive housing retention rate of 86 percent. Moreover, significant decreases in hospitalizations and emergency room visits indicate improved health and behavioral health outcomes. In addition to improving the quality of life for these 50 individuals, estimates show considerable cost savings as a result of fewer days spent in ERs, hospitals, and jails.

- **Skid Row Families Demonstration Project** – A total of 241 families have been placed into permanent housing. Of these families, 93 percent have successfully maintained permanent housing for six or more months (221 have maintained their permanent housing for 12 months or more, and three families have maintained permanent housing for seven to 12 months). For the first six months in permanent housing, families are offered home-based case management. Consistent contact has enabled the Housing First Case Managers to develop positive relationships based on trust. Case management has included linking families to various supportive services, including: community resources, mental health referrals, school referrals, job training referrals, money management, and financial planning. After six months of home-based case management to help families stabilize, the majority of families received follow-up phone calls to ensure they are doing well and are not in crisis.

- **Homeless Courts** – A total of 2,153 individuals have had their warrants or citations dismissed as a result of successful completion of mental health and/or substance abuse treatment requirements of the Los Angeles County Homeless Court and Santa Monica Homeless Community Court. In addition, 12 individuals have graduated from the Co-Occurring Disorders Court to have charges dismissed. As a result of having outstanding warrants, citations, or charges resolved, these individuals have been able to move forward by securing employment, reconnecting with their families, and planning for their future. For example, one participant obtained his GED, became a certified cook and hopes of owning his own restaurant. Another participant said that the program has changed his life by helping him achieve sobriety for over 17 months and reunite with his family.

- **Los Angeles County Housing Resource Center (LACHRC)** – The online database provides information on housing listings for public users, housing locators, and caseworkers. Over 5.3 million searches have been conducted by users to receive listings. The LACHRC is an excellent example of using technology to make information more accessible, and clients are very grateful for this service. In October 2009, the LACHRC added a pre-screening feature to determine HPRP program eligibility and further improve system navigation for clients.

IV. PROGRAM NARRATIVE (included in Attachment B)

Each quarter, programs provide information on successes, challenges, and action plans. A review has identified four common themes in implementing strategies to reduce homelessness: collaborative partnerships, innovative processes, outreach strategies, and leveraged funds.

Client Success Stories

In February 2009, Client A became homeless for the first time after raising eight children as a single mother. Her Supplemental Security Income (SSI) benefits were suspended due to an 11-year-old warrant which surfaced at the time of her recertification for SSI benefits. Client A was evicted after being stable in her apartment for 10 years. As a result, she lost everything including her furnishings, clothes and family support. Under extreme stress of being homeless, her mental health symptoms increased causing relapse. She reported frequent thoughts of doing harm to herself. Her therapist and case manager at the DMH West Central office in Service Area 6 intervened and provided her with supportive services to address her housing and psychiatric needs. She was referred to an emergency shelter where she stayed for 14 months and was also hospitalized for kidney complication. After stabilization, the case manager and the housing specialist continued to provide support to secure permanent housing. She was provided with housing leads and was accompanied on housing interviews. Just before her 60th birthday in April 2010, she was accepted at A Community of Friends low income apartments in Compton where she is currently paying 30% of her General Relief payment until her SSI is re-instated. She has since been reunited with her children and grandchildren.

-Housing Specialists participant

The City of Long Beach Homeless Veterans Initiative (HVI) street outreach staff connected with a Vietnam War veteran who had lived in the Long Beach wetlands since 1997. Due to a medical condition, Client C was blind in one eye. Through the collaborative efforts of the Long Beach Police Department Quality of Life unit and the City's veteran-specific street outreach worker, the client underwent surgery at the Long Beach VA medical center to restore his vision. With the assistance of the veteran-specific case manager at the City of Long Beach Multi-Service Center (MSC), the client obtained GR benefits, while he applies for SSI benefits. The client also entered Project Achieve, a transitional living program that will help him to progress towards attaining permanent housing.

-Long Beach Services for Homeless Veterans participant

Client L came into the program with her four-year-old daughter scared and in crisis. During her 57-day stay at the emergency DV shelter, she worked closely with staff on meeting her advocacy goals and addressing all the emergency needs of the family. All medical, financial, legal and future housing needs were addressed. Client L was able to sign up for CalWORKs assistance and received transportation assistance from WCCS. When she left the program, she returned to the work force. She was able to move out to a new apartment and for the first time in a long time, she and her daughter were safe and had the confidence to live life free of abuse and fear.

-Women's and Children's Crisis Shelter participant

V. STRENGTHENING COUNTY HOMELESS COORDINATION

On November 17, 2009, the County Board of Supervisors passed a motion instructing the CEO, with assistance from DCFS, DHS, DMH, DPSS, the CDC, and LAHSA, to develop recommendations on how to strengthen the CEO's ability to oversee, coordinate and integrate Countywide homeless service delivery so that homeless individuals and families can more successfully find safe and permanent housing. In response, a CEO report to the Board on January 4, 2010 made three main recommendations to strengthen the County's homeless strategy. The CEO provided another update to the Board in May 2010 which informed of progress made in each of the three focus areas –

1. Leverage funds to maximize resources
2. Coordinate a regional approach among partners
3. Address cost avoidance

Significant progress has been made to develop collaborative working partnerships with multiple public and private agencies and philanthropic organizations. It is the County's intent to work with the Special Needs Housing Alliance (SNHA) to put together an action plan with a timeline that would continue to align resources, while at the same time not increase net County cost (NCC) and maximize resources to serve homeless individuals and families.

In July 2010, the CEO hired Libby Boyce to fill the position of the County Homeless Coordinator. Libby previously was the Homeless Coordinator for the Department of Health Services. The CEO will continue to develop partnerships with cities and communities throughout the County to create regional solutions to address homelessness. For example, the SNHA has already begun to bring developers and service providers together. Moreover, as many of the one-time funded HPI programs have expended funds, we propose to change the format and content of the HPI status report. The new quarterly report will focus on major County-funded projects as well as the progress of the SNHA, and details of each program's activities and services will no longer be included. The Integration of successful strategies from pilot projects into the daily operations of County departments will become a focus.

Monthly Board briefings and homeless coordination meetings that include staff from Board offices, County departments, LAHSA, CDC, and several cities will continue to provide updates on the County's homeless and housing budget and programs. The forum is an opportunity to discuss various homeless issues. Each of these efforts and the Board's continued investment will ensure that the initiative to reduce homelessness in Los Angeles in successful.

VI. Acknowledgements

We would like to acknowledge the time and effort of the following who have contributed to the collection and review of the HPI program data included in this report.

A Community of Friends	Dora Leong Gallo Nancy Neilson Rebecca Ricketts Dorene Toutant
Beyond Shelter	Zoe Ellas Tanya Tull
Catalyst Foundation for AIDS Awareness and Care	Elizabeth Gomez Susan Lawrence
Century Villages at Cabrillo	Brian D'Andrea Aaron Wooler
Chief Executive Office, County of Los Angeles	Julie Beardsley Elizabeth (Libby) Boyce Lynn Cao Michael Castillo Rosemary Gutierrez Maggie Ly
City of Long Beach	Patti LaPlace Rene Miyasato Susan Price
City of Pasadena	Anne Lansing
City of Pomona	Jan Cicco
City of Santa Monica	Setareh Yavari
CLARE Foundation, Inc.	Bridget Goldberg Debbie Kaste
Cloudbreak Compton, LLC	Scott Fichter
Community Development Commission (Los Angeles County)	Virginia Adame Terry Gonzalez Kayla Kitson Larry Newnam Elena Quon Carolina Romo Lois Starr Scott Stevenson
Department of Children and Family Services, County of Los Angeles	Bedrae Davis Theresa Rupel
Department of Health Services, County of Los Angeles	Vicki Nagata Leepi Shimkhada
Department of Mental Health, County of Los Angeles	Maria Funk Adrienne Gee Juataun Mark Mary Marx Jaime Nahman Anh Tran Reina Turner Joo Yoon
Department of Public Social Services, County of Los Angeles	Consuelo Ayala LaShonda Diggs Ken Krantz Charlotte Lee Judith Lillard Dorothea Manns Charles Medlin

Department of Public Social Services (continued)	Antonio Roldan Jose Salgado
Homes for Life Foundation	Deborah Gibson
JWCH Institute, Inc.	Al Ballesteros Eduardo Gonzalez Paul Gregerson
Los Angeles Homeless Services Authority (LAHSA)	Steve Andryszewski Rachel Citron Michael Nailat
National Mental Health Association of Greater Los Angeles	Lesley Braden Jamie Gonzalez Sarah Tower
Ocean Park Community Center (OPCC)	Cherry Castillo Debby Maddis
PATH Achieve Glendale	Jerome Nilssen Natalie Profant Komuro
PATH Partners	Joel John Roberts (Gateway Cities COG) Anna Topolewski (Long Beach) Margaret Willis (Gateway Cities COG)
Probation Department, County of Los Angeles	Hania Cardenas Michael Verner Maria Vicente
Public Counsel Law Center	Jennifer Amis Sarah Evans Paul Freese
Salvation Army	Alen Davtian
San Gabriel Valley Council of Governments	Nicholas Conway Bekah Cooke
ServeLA	Adrian Koehler
Sheriff's Department, County of Los Angeles	Lt. Edward Ramirez
Skid Row Housing Trust	Katherine Hill Shannon Parker
Southern California Alcohol and Drug Programs, Inc. (SCADP)	Heidi Hobart-Ferraro
Southern California Housing Development Corp. of Los Angeles	Sandra Peterson
Special Service for Groups (SSG)	Cheryl Branch Tonia Johnson (HOPICS) Carlos Moran
Step Up on Second	Aaron Criswell Tod Lipka
Superior Court of California (County of Los Angeles)	Jessica Delgadillo Ken Kallman Saida Lopez
Tri Cities Mental Health	Gilbert Saldate
Union Rescue Mission	Jessica Brown-Mason Sara Farnsworth Carrie Gatlin Bert Paras
Volunteers of America of Los Angeles	Jim Howat Veronica Lara Alma Martinez
Women's and Children's Crisis Center	Dolores Salomone

Table of Homeless Prevention Initiative (HPI) Programs

Attachment B

Pg.	Strategy	Program	Indicator (to date)	Target	Funding	Budget
		Families (I)				
3	❶	1. Emergency Assistance to Prevent Eviction for CalWORKs Non-Welfare-to-Work Homeless Families	10,691 families received eviction prevention to prevent homelessness	2,079	One-Time	$500,000
	❶	2. Moving Assistance for CalWORKs Non-Welfare-to-Work and Non-CalWORKs Homeless Families	5,115 families received moving assistance and permanent housing	1,305 450	One-Time	$1,300,000
	❶	3. Rental Subsidy for CalWORKs and Non-CalWORKs Homeless Families	211 families received rental subsidies to prevent homelessness	1,475	One-Time	$4,500,000
5	❺	4. Housing Locators	573 families placed into permanent housing	n/a	*DPSS*	$1,930,000
6	❻	5. Skid Row Families Demonstration Project	241 families placed into permanent housing	300	Board Approved	$9,212,000
8	❺	6. Multi-disciplinary Team Serving Families	567 families received case management services	n/a	Ongoing	$494,000
		Transition Age Youth (II)				
10	❶	7. Moving Assistance/Rental Subsidies for TAY – DCFS	554 TAY received rental subsidies	335 3yr	One-Time	$1,750,000
10	❶	8. Moving Assistance/Rental Subsidies for TAY – Probation	366 TAY received rental subsidies	335 3yr	One-Time	$1,750,000
		Individuals (III)				
12	❷	9. Access to Housing for Health (AHH)	104 clients placed into permanent housing 85% decrease in inpatient days; 76% in ER visits	115 cap	Board Approved	$3,000,000
14	❺	10. Benefits Entitlement Services Team for the Homeless (B.E.S.T.)	47 individuals received SSI approval	Individuals	One-Time	$2,000,000
15	❺	11. Center for Community Health Downtown Los Angeles	5,824 individuals received health care	n/a	Ongoing	*$186,000
16	❺	12. Co-Occurring Disorders Court	57 individuals placed into transitional housing	n/a	Ongoing	$200,000
19	❷	13. DPSS General Relief Housing Subsidy & Case Management Project	3,395 homeless GR participants received housing subsidies for housing placement	900 at a time	Ongoing	$4,052,000
20	❷	14. DPSS-DHS Homeless Release Project	499 potentially homeless participants received benefits	n/a	Ongoing	$588,000
20	❷	15. DPSS-Sheriff's Homeless Release Project	3,377 potentially homeless individuals received benefits	n/a	Ongoing	$1,171,000
22	❷	16. Homeless Recuperative Care Beds (DHS)	545 individuals were served through this program 70% decrease in hospitalizations; 28% in ER visits	490/2yr	One-Time	$4,739,000
24	❺	17. Housing Specialists (most clients are individuals)	824 placed into permanent housing	n/a	*DMH MHSA*	$923,000
25	❷	18. Just In-Reach Program	285 individuals received public benefits	Individuals 400/2yr	One-Time	$1,500,000
27	❻	19. Long Beach Housing Now – PATH Ventures	10 chronically homeless placed in transitional housing		Board Approved	$300,069
28	❹	20. Long Beach Services for Homeless Veterans (mostly individuals)	376 veterans received case management services	n/a	Ongoing	$500,000
31	❻	21. Los Angeles County Homeless Court Program	2,035 individuals with citations or warrants processed	n/a	Ongoing	$379,000
33	❶	22. Moving Assistance for Single Adults in Emergency/Transitional Shelter or Similar Temporary Group Living Program	438 individuals received moving assistance to prevent homelessness	until 2,000	One-Time	$1,100,000
34	❻	23. Project 50	68 chronically homeless placed into permanent housing	50	One-Time	$3,600,000
36	❻	24. Santa Monica Homeless Community Court	118 individuals with citations or warrants dismissed	90	Board Approved	$571,000

Table of Homeless Prevention Initiative (HPI) Programs

Attachment B

	Program	Indicator (to date)	Target	Funding	Budget
38 ❻	25. Santa Monica Service Registry (programs a and b)	81 chronic homeless individuals have participated	n/a	3rd District	$1,178,000
	Multiple Populations (IV)				
42 ❻	26. Los Angeles County Housing Resource Center	Over 5.3 million housing searches conducted	n/a	Ongoing	$202,000
43 ❺	27. LAHSA contracted programs	9,372 placements into housing	n/a	One-Time	$1,735,000
43 ❺	28. PATH Achieve Glendale (families and individuals)	298 placements into permanent housing	n/a	One-time	$200,000
45 ❸	29. Pre-Development Revolving Loan	$3.7 mil. loan closed for 45 affordable units for seniors	n/a	One-Time	$20,000,000
46 ❺	30. Project Homeless Connect	2,212 households connected to services (since 12/09)	n/a	One-Time	$45,000
47 ❸	31. **City and Community Program - CCP (V)**	$11.6 m capital, $20.6 m City Community Programs	Multiple	One-Time	$32,000,000
73 ❹	32a. **San Gabriel Valley Council of Governments - COGs (VI)**	Final report completed in March 2009	n/a	Ongoing	$200,000
74 ❹	32b. Gateway Cities Homeless Strategy	Final report completed in March 2009	n/a	Ongoing	$135,000
	HPI Funding Total (excludes Board approved operational support (FY 2006-07) administrative and evaluation costs), *Ongoing costs expected to be $76,000				**$101,940,069**

47 ❸	***City and Community Program (CCP) Funds***	**Service ($)**	**Capital ($)**
a.	*Catalyst Foundation for AIDS Awareness and Care – Expansional Supportive Services Antelope Valley*	1,800,000	
b.	*City of Pomona – Community Engagement & Regional Capacity Building*	1,079,276	
c.	*City of Pomona – Integrated Housing & Outreach Program*	913,975	
d.	*A Community of Friends – Permanent Supportive Housing Program*	$1,800,000	
e.	*Homes for Life Foundation – HFL Vanowen**	369,155	*369,155
f.	*Nat'l Mental Health Assoc. of Greater L.A. – Self Sufficiency Project for Homeless Adults and TAY Antelope Valley*	900,000	
g.	*Nat'l Mental Health Assoc. of Greater L.A. – Self Sufficiency Project for Homeless Adults and TAY Long Beach*	1,340,047	
h.	*Ocean Park Community Center (OPCC) – HEARTH*	1,200,000	
i.	*Skid Row Housing Trust – Skid Row Collaborative 2 (SRC2)*	1,800,000	
j.	*So. California Alcohol & Drug Programs, Inc. (SCADP) – Homeless Co-Occurring Disorders Program*	1,679,472	
k.	*Special Service for Groups (SSG) – SPA 6 Community Coordinated Homeless Services Program*	1,800,000	
l.	*Union Rescue Mission – Hope Gardens Family Center*	756,580 1,096,930	646,489
m.	*Volunteers of America of Los Angeles – Strengthening Families*	1,000,000	
n.	*Women's and Children's Crisis Shelter*	300,000	
	Beyond Shelter Housing Dev. Corp. – Mason Court Apartments		$680,872
	Century Villages at Cabrillo, Inc. – Family Shelter EHAP I & II		1,900,000
	City of Pasadena – Nehemiah Court Apartments	102,685	858,587
	CLARE Foundation, Inc. – 844 Pico Blvd., Women's Recovery Center	1,050,000	1,000,000
	Cloudbreak Compton LLC – Compton Vets Services Center	322,493	1,381,086
	So. California Housing Development Corp. of L.A. – 105th and Normandie	200,000	600,000
	The Salvation Army – Bell Shelter Step Up Program		500,000
	Total for Service and Capital	$19,510,613	$7,936,189
	Grand Total for CCP*	**$27,446,802**	

**Actual total of $32 million includes administrative costs;* $369,155 originally awarded in capital funding to HFL will go to another capital project in SPA 2.

For this report, unless specified: Fiscal Year (FY) refers to the all quarters of FY 2009-10 (July 1, 2009 – June 30, 2010). Cumulative refers to the number of clients served to date. Note: complete demographic information may not have been provided.

I. PROGRAMS FOR FAMILIES

1, 2, 3) DPSS Programs: Moving Assistance, Eviction Prevention, and Rental Subsidy

Goal: Assist families to move into and/or secure permanent housing.

Budget: (One-Time Funding)

1) Emergency Assistance to Prevent Eviction for CalWORKs Non-Welfare-to-Work Homeless Families (EAPE)	$500,000
2) Moving Assistance for CalWORKs Non- Welfare–to-Work and Non-CalWORKs Homeless Families	$1,300,000
3) Rental Subsidy for CalWORKs and Non-CalWORKs Homeless Families	$4,500,000

Table A.1: DPSS Services for Families by Program
FY 2009-10, through June 30, 2010

Program (unduplicated count)	FY	Cumulative
1) Emergency Assistance to Prevent Eviction for CalWORKs Non-Welfare-to-Work Homeless Families	4,675 received eviction prevention	10,691 received eviction prevention
2) Moving Assistance for CalWORKs Non- Welfare-to-Work and Non-CalWORKs Homeless Families	1,761 received moving assistance and permanent housing	5,115 received moving assistance and permanent housing
3) Rental Subsidy for CalWORKs and Non-CalWORKs Homeless Families	Program ended in FY 2008-09.	211 received rental subsidies for permanent housing

Table A.2: DPSS Measures by Program
FY 2009-10, through June 30, 2010

Program (unduplicated count)	Number of applications received		Percent of applications approved		Average amount of grant	
	FY	To date	FY	To date	FY	FY 08-09
1) Emergency Assistance to Prevent Eviction for CalWORKs Non-Welfare-to-Work Homeless Families	6,327	15,330	74%	70%	$665	$649
2) Moving Assistance for CalWORKs Non-Welfare-to-Work and Non-CalWORKs Homeless Families	2,438	7,360	72%	69%	$821	$821
3) Rental Subsidy for CalWORKs and Non-CalWORKs Homeless Families	137	215	96%	99%	-	$427

Each program reported an average of three business days to approve an application.

January 2009 –June 2010	Moving Assistance	Rental Subsidy	Emergency Assistance
Homeless/At-Risk Families	2,526	58	6,382
Female	4,568	105	11,287
Male	3,029	91	8,545
Hispanic	2,870	85	11,172
African American	4,230	81	7,590
White	183	23	533
Asian/Pacific Islander	107	2	210
Native American	6	2	16
Other	197	3	211
15 and below	4,750	121	9,262
16-24	738	11	1,709
25-49	2,097	64	3,569
50+	8	-	20

1) Moving Assistance (MA) for CalWORKs Non-Welfare-to-Work and Non-CalWORKs Homeless Families

Successes: During this past quarter through the MA program, a total of 423 families received financial assistance to secure permanent housing and/or received assistance for one or more of the following: a) utility turn-on fees; b) truck rental; and c) appliance purchases (stove and/or refrigerator).

Challenges: Finding safe and affordable housing is a big challenge for low-income families in Los Angeles County.

Action Plan: Utilize and promote the use of websites such as the Los Angeles County Housing Resource Center to assist families in locating safe and affordable housing.

Client Success Story: With financial assistance received through the MA program, a mother was able to secure permanent housing for herself and her daughter. Now that the family has resolved the housing issue, the mother is focusing on job search and education.

2) Rental Subsidy for CalWORKs and Non-CalWORKs Homeless Families

Successes: This program has provided rental subsidy assistance to 58 families for this quarter.

Challenges: Due to budget constraints, this program was terminated for new program applicants effective February 28, 2009.

Action Plan: The action plan is to continue assisting families that were approved prior to the termination of this program (2/28/09).

Client Success Story: A CalWORKs family who became homeless due to a domestic violence situation accessed GAIN supportive services after resolving a CalWORKs program sanction with the assistance of the participant's HCM. The participant found permanent housing from a listing the HCM provided to her from the Socialserve.com/restricted area search. The participant qualified for Permanent Homeless Assistance, Moving Assistance and the 12 Month Rental Subsidy Program. Through the collaborative efforts of the DPSS HCM, the Housing Resources Eligibility Unit, GAIN and LAHSA (shelter), this family was able to move from a DV shelter into permanent housing.

3) Emergency Assistance to Prevent Eviction (EAPE) for CalWORKs Non-Welfare-to-Work Homeless Families

Successes: Through the EAPE program, a total of 1,119 families at-risk of homelessness received assistance to maintain their current housing and/or maintain their utility services this quarter.

Challenges: Due to the high volume of applications for EAPE, funding is always a challenge.

Action Plan: DPSS continues to evaluate families requesting assistance with past-due rent and/or utilities for the State-approved Homeless Assistance Arrearages Payment program in order to leverage HPI funds.

Client Success Story: A single mother suffering from cancer and undergoing chemotherapy was at risk of becoming homeless. With the assistance the family received via the EAPE program, they were able to remain housed near the hospital where the mother was receiving treatment. In addition, the family also received assistance to pay for utilities.

4) Housing Locators - DPSS

Goal: Assist families to locate and secure permanent housing.
Budget: $1.93 million (DPSS CalWORKs funding)

Table A.3: Housing Locators Measures
FY 2008-09, through December 31, 2008

(unduplicated count)	FY	Cumulative
Homeless Families	471	1,685
Housing (permanent)	210	573
Number of referrals to Program	471	1,685
Average time to place family (days)	60-180	60-180

Successes: Through the assistance of the Housing Locators, 210 families were placed into permanent housing during October-November 2008. No placements were made in December 2008.

Challenges: Due to budget constraints, the Housing Locators contract has been officially terminated effective December 15, 2008. Referrals to the Housing Locators program ended effective October 15, 2008.

Action Plan: The Housing Locator's program contract was terminated effective December 15, 2008.

5) Skid Row Families Demonstration Project

Goal: Locate 300 families outside of Skid Row and into permanent housing.
Budget: $9.212 million (Board Approved Funding)

HPI funding for this project ended on December 18, 2009.

Table A.4: Skid Row Families Demonstration Project Participants and Services
FY 2009-10, through December 31, 2009

(unduplicated clients)	Cumulative (3/31/09)		Cumulative
Homeless Families	300	Moving assistance	175
(individuals)	1,084	Eviction prevention	40
Female	273	Housing (emergency/transitional)	300
Male	27	Housing (permanent)	241
		Rental subsidy	33
Hispanic	68		
African American	187	Education	15
White	12	Job training/referrals	65
Asian/Pacific Islander	3	Job placement	14
Native American	-	Section 8	77
Other	30		
		Case management	275
15 and below	619	Life skills	456
16-24	80	Mental health/counseling	53
25-49	295	Transportation	224
50+	15	Food vouchers	390
		Clothing	18

Program Specific Measures		Cumulative
Number of families enrolled in project	300	300
Number of families relocated from Skid Row area within 24 hours	-	-
Number of families placed into short-term emergency housing	-	300
Number of adults who received referrals to community-based resources and services	386	420
Number of children who received intervention and services	679	850
Number of families who received monitoring/follow up after 6 months case management	353	64
Number of families no longer enrolled (termination or dropped out of program)	59	50
Number of families who received an eviction notice during the last 3 months	30	-
Number of families who lost their permanent housing during the last 3 months	6	-

Emergency Housing/Case Management	Quarter
Average length of stay in emergency housing:	-
Most frequent destination (permanent housing):	-
Case management (level 2)	
Average number of case management hours for each participant per month:	116 hours
Total case management hours for all participants during current reporting period:	348 hours
Number of cases per manager:	3 cases

Longer-term Outcomes	6 mo	12 mo
Continuing to live in housing	3	221
Obtained employment	34	
Maintained employment	55	
Enrolled in education program/school	42	
Completed high school/GED	4	
Case management	224	
Mental health	50	
Substance abuse treatment (residential)	5	
Reunited with family	176	

Additional measures to be provided after close of program (report forthcoming):

- Gainful employment - (Number of individuals who obtained employment)
- Access to appropriate and necessary mental health or substance abuse treatment - (Number of individuals who received mental health services, Number of individuals who received substance abuse treatment)
- Educational stability for children - (Number of children)
- Socialization/recreational stability for children - (Number of children)
- Services to assist domestic violence victims - (Number who received domestic violence services/counseling)

Successes: A total of 300 families were referred by the Skid Row Assessment Team to Beyond Shelter and the Skid Row Families Demonstration (SRFD) Project. Beyond Shelter placed 241 of 300 participant families into permanent housing, primarily with the assistance of a Housing Authority of the City of Los

Angeles (HACLA) Section 8 subsidy. The majority of these families have remained in permanent housing for at least 12 months. As of December 31, 2009, 221 families have successfully completed 12 months in permanent housing. During the current reporting quarter, seven families completed 12 months and three families completed 7 to 12 months. Only seven families have reported to Beyond Shelter that they were evicted from their apartments and have returned to homelessness. Each incidence of eviction was a result of a crisis, including mental health issues, substance abuse, or domestic violence. A total of 59 of 300 families were terminated from the program for non-compliance or loss of contact, prior to a move into permanent housing.

The current focus of the SRFD Project remains on assisting families with stabilizing in permanent housing. Presently, there are three active cases at the end of the second quarter and case managers have continued to provide specialized, individualized, and intensive support for each family. With most of the families' cases now closed or terminated from the program, the case manager's task has been to provide support to previous clients returning for assistance with public social services, childcare referrals and community resources such as food banks. Former participants have also needed guidance regarding available resources for employment, including at least one client who Beyond Shelter was able to link with the Transitional Subsidized Employment (TSE) program through the Department of Public Social Services (DPSS). With support of their former case managers, this quarter several families were assisted with the HACLA annual recertification process. These families needed assistance to the extent that they may have lost their Section 8 vouchers without direct and specific guidance through the process.

Challenges: HACLA recently began sending notices to many successfully housed clients indicating that their Section 8 voucher will be re-issued to them for a smaller-sized unit, unless they opt to remain in their current unit and pay the higher tenant portion of rent. The higher portion of rent can increase to as much as triple the amount of rent the family is able to pay. If a family were to remain in their current unit, they would not be able to afford the rent and would certainly be evicted and, quite probably, become homeless again. Approximately 79 of the 241 families who moved to permanent housing will receive notice of a change in the formula during recertification this year and will be required to relocate. The majority of these families faced many barriers to permanent housing when they entered the SRFD Project, and will experience similar barriers to obtaining subsequent housing even if they do accept the "down-sized" Section 8 voucher. Barriers to housing that these families face include: multiple past evictions, poor credit, poor negotiating skills, and poor landlord references. Furthermore, their current landlords legally have 21 days to return their security deposits, less cleaning costs and any damages incurred beyond normal wear and tear to the apartment. Move-in costs will inevitably become a barrier to relocation. Without housing counseling or a housing relocation specialist to assist them, they will have difficulty locating property owners who accept Section 8 vouchers, and they will have a difficult time negotiating their leases.

If forced to relocate, Beyond Shelter anticipates that many of these families will be unable to utilize their Section 8 vouchers, will have them expire, and will ultimately become homeless again. These families are in need of help, but unfortunately the SRFD Project contract has ended and Beyond Shelter is not currently staffed to fully assist them with the relocation process.

Action plan: Beyond Shelter case managers operating under other government contracts are providing support to at least four former clients who have contacted Beyond Shelter regarding their HACLA voucher re-issuance. At this time, the support consists mainly of guiding them to respond to all HACLA correspondence, so that they are not automatically terminated for failure to respond. Because many of the families are extremely dysfunctional, even the simplest steps in the Section 8 recertification process are difficult to follow; most must be provided with clear and concise guidance. Case managers have helped them understand what they are reading, and have directed them on how to respond to HACLA immediately. They have also referred clients to Legal Aid to keep them informed of the legal process. Additionally, case managers are referring families to their local L.A. City Homelessness Prevention and Rapid Re-housing (HPRP) programs to determine their eligibility for homeless prevention financial assistance, which could potentially provide relocation assistance. With the help of a Housing Specialist, however, to find landlords willing to participate in the Section 8 Program and willing to rent apartment units to families with prior evictions, poor credit, and histories of homelessness, it is anticipated that the majority of these families will lose their Section 8 vouchers and become homeless again.

Client Success Story: Client D is a 54-year-old African American male, with custody of his five-year-old grandson. His grandson's mother has been incarcerated since her son's birth, and his father was

murdered. Prior to this episode of homelessness, Client D was very successful; he completed high school, took college courses in psychology, and worked over 15 years in social services. Client D and his grandson became homeless after things did not work out between him and his girlfriend, and they were asked to leave the apartment they shared. They moved from family and friends to motels, but his main concern was establishing a stable environment for his grandson. Through DPSS, they were placed in a motel but eventually that assistance was exhausted. Desperate, and living in the streets, D sought assistance in Skid Row. They were enrolled into the SRFD Project in July 2007 and were immediately placed into a motel. At the time of their arrival, the family's service needs intensity level was assessed at high intensity due to D being a single grandfather with a child under 12.

The family was soon moved into a master-leased apartment (MLA), which provided them with a stable home environment. Client D was assisted with the Section 8 Housing Choice Voucher application with HACLA and was provided tenant education. Prior to moving into permanent housing, the family's service needs were re-assessed to low intensity due to the stability they achieved while living at the MLA. Utilizing their Section 8 voucher, and with guidance from a Housing Relocation Specialist, Client D signed a lease with the property owner and converted his one-bedroom MLA to permanent housing in May 2008.

Client D's main motivation for finding permanent housing has been to provide a safe home for his grandson. The client battles with high blood pressure, kidney problems, and severe arthritis and receives regular medical treatment. Although his ailments are difficult to deal at times, the client provides his grandson with a safe and loving environment, and constant stimulating and educational activities. His grandson began school last fall and is thriving in his new environment. Beyond Shelter provided guidance and assistance with the SSI application for the client to receive state disability benefits for his medical conditions, and after approximately one year, he was approved to receive SSI benefits.

6) Multi-Disciplinary Team Serving Families
Budget: $494,000 (Ongoing Funding)

Table E.5: Multi-Disciplinary Team
FY 2009-10, through June 30, 2010

(unduplicated clients)	FY		FY
Homeless Families	306	Job training	3
(individuals)	947	Job placement	1
Female	586	Housing (transitional)	26
Male	361	Housing (permanent)	6
		Moving assistance	1
Hispanic	274	CalWORKs	22
African American	588		
White	87		
Asian/Pacific Islander	14	Case management	567
Native American	12	Health care	338
Other	21	Mental health care	121
		Transportation	18
15 and below	531		
16-24	110		
25-49	286		
50+	30		

Case management (level 2)	
Average number of case management hours for each participant per month:	3 hours
Total case management hours for all participants during current reporting period:	1,350 hours
Number of cases per manager:	14 cases

The Skid Row Assessment Team (SRAT) originated as a result of a Board motion in December 2004. It is a collaborative between the County departments of Children and Family Services (DCFS), Public Social Services (DPSS), Mental Health (DMH), and Public Health (DPH). On July 1, 2009 the SRAT moved into the Family Assessment Center located at the Center for Community Health Downtown Los Angeles. The SRAT is committed to attaining the goals of assuring child safety, providing ongoing case management and enforcing the zero tolerance goal for families on Skid Row. The SRAT is excited about the new opportunities that have been identified during the collaboration between County departments and the community agencies that will assist Skid Row families in the care and protection of children.

Successes: During this quarter, the SRAT encountered 66 new families. In collaboration with the Union Rescue Mission, LAHSA, and the SRAT, 71 families relocated outside of Skid Row during this period with nine moving into permanent housing and 28 families moving into transitional housing. During this quarter, a large number of services were provided successfully to the homeless families including the following: 10 families were approved and issued Homeless Assistance by DPSS, seven families opened CalWORKs cases, and 70 health and safety assessments were provided through DPH. Seventy-seven individuals were referred for clinical assessments through DMH. Seventy-two families received child safety assessments through DCFS with 16 of the families receiving referrals for Family Preservation or Family Support services. During this quarter, the SRAT focused on identifying families who had moved into permanent housing and who could benefit from the DCFS' Strengthening Needy Family funds. Based upon their low but sustainable income, some of the families met the qualifications for eligibility to receive household items, goods or financial support to meet their household needs. The SRAT provided direct assistance by meeting with the families to complete their applications to ensure accuracy and correctness to ensure rapid processing.

Challenges: A growing challenge during the past quarter was working with families who are headed by single fathers and intact two parent families who have sought refuge at the missions. Throughout the time the family is at the mission, case management focused on identifying and removing barriers to achieving placement into transitional housing as an interim solution to permanent housing. At any one moment approximately 13% of the families are headed by a single father. As well, there is a growing population of intact families (24-37%) headed by married couples who are homeless. Regardless of consistent efforts from case managers to link these families with resources, most were unable to find other shelters or transitional programs to relocate because of limited programming for these homeless populations.

Action Plan: The SRAT is working collaboratively with the missions to develop resources to meet the needs of these two populations. Plans are also in development through the missions to create new homeless family programs outside of the Skid Row area that will provide some limited resources to meet this special need.

Client Success Story: Client D is a single father of two children. The father and one child are undocumented residents of the U.S. The family came to the attention of the SRAT in January 2010. According to the father, the mother abandoned the family approximately a year and a half ago. He is the primary caretaker and has been providing for the family on income he earned from working part-time as a painter. The father denied having a support system, friends, or family residing in the Los Angeles area. While making efforts to support his children, they were not enrolled in school, because he was unable to retrieve immunization records and identification papers required for enrollment.

According to the father, the family was living in a friend's garage until January, when he had to move because the friend stopped the utilities to the garage. The father stated he was paying $450 a month to live in the garage. While staying at the Union Rescue Mission on Skid Row, Client D was assessed by the SRAT. It was determined that he would be eligible for benefits for one child and be able to receive Homeless Assistance through DPSS.

Client D was very receptive to services. The Homeless Case Manager from the District Office along with the SRAT and URM case managers provided Client D intensive services to assist the family to relocate from the Skid Row area. With some apprehension and fear, the father worked with the team and then agreed to placement temporarily at the Chavez house until accepted into the Salvation Army Transitional Shelter. During this period the father was assisted with applying for the DPSS CalWORKs and Homeless Assistance Programs, filing for child support, obtaining immunization for the children, and obtaining identification cards from the Mexican Consulate. In addition, he received assistance to locate child care to free up time to look for full time employment. Client D also enrolled in parenting classes to improve his parenting skills and enrolled his children in school.

After much effort, the family was accepted and stabilized in the Salvation Army transitional program where his children began school after one and a half years. Client D continues to work closely with his case managers to pursue full time employment and permanent housing.

II. PROGRAMS FOR TRANSITION AGE YOUTH

7 and 8) Moving Assistance for Transition Age Youth

Goal: Assist Transition Age Youth (TAY) to move into and secure permanent housing.
Budget: $3.5 million (One-Time Funding)

Table B.1: Moving Assistance for Transition Age Youth Participants
FY 2009-10, through June 30, 2010

	Total	Probation		DCFS	
		FY	Cumulative	FY	Cumulative
Transition Age Youth	1,013 (100%)	133 *(new)	491	162 *(new)	**596
Female	576 (57%)	54	204	120	372
Male	437 (43%)	79	287	42	150
Hispanic	244 (24%)	25	119	38	125
African American	708 (70%)	105	353	110	355
White	43 (5%)	3	13	14	30
Asian/Pacific Islander	6 (1%)	-	6	-	-
Native American/Other	-	-	-	-	-
16-24	1,013 (100%)	133	491	162	522

* During the First Quarter of FY 2009-10, 62 new TAY were enrolled; 179 TAY continued to participate.
**FY 2008-09 total was 360. FY 2007-08 DCFS demographic participant data was duplicative (duplicated total 464); cumulative demographic information includes FYs 2008-09 and 2009-10.

Table B.2: Moving Assistance for Transition Age Youth Services
FY 2009-10, through June 30, 2010

(unduplicated count)	Total	Probation		DCFS	
	FY	FY	Cumulative	FY	Cumulative
Moving assistance	38	2	255	36	240
Rental subsidy	131	8	366	123	554
Housing (permanent)	168	133	444	35	269
Eviction prevention	1	-	-	1	1
Any supportive service+	26	26	127	-	64
Education	38	1	10	37	95
Job training, referrals	-	-	-	-	35
Job placement	237	237	86	-	-
Case management	210	133	491	77	511
Life skills	-	-	-	-	8
Mental health	-	-	-	-	1
Transportation	12	-	-	12	119
Food vouchers	3	-	-	3	46
Clothing	10	-	-	11	83
Auto insurance	1	-	-	1	12

+Probation does not break down supportive service by type, except for job placement.

Table B.3: Longer-term Outcomes for Transition Age Youth
(6 or more months), FY 2009-10, Fourth Quarter

	Probation	DCFS
Continuing to live in housing	255	46
Obtained employment	8	6
Maintained employment	138	6
Enrolled in educational program/school	-	5
Received high school diploma/GED	-	4

Table B.4: Program Specific Measures for Transition Age Youth
FY 2009-10, through March 31, 2010

	Probation		DCFS	
	FY	Cumulative	FY	Cumulative
Number of new approvals	101	538	85	425
Average cost per youth	$2,210	*$3,806	$3,500	*$2,663
Number of program participants satisfied with program services	202 (of 202)	450 (of 452)	20	155
Number of pregnant/parenting youth placed in permanent housing	13	103	1	72
Number exited housing	39	60	-	324
Number remaining in permanent housing and receiving assistance at 6 months	n/a	n/a	16	94

*Average cost per youth for FY 2008-09; in FY 2007-08, the average cost was $3,816 for Probation.

Probation– Moving Assistance for TAY

Successes: During the quarter, 211 youth were served, and 32 additional youth were placed in permanent housing. The program enables youth to maintain employment, obtain better employment, or continue their educational aspirations while staying out of trouble with the law. The program participants' low recidivism can be attributed to the Transitional Permanent Project (TPP).

Challenges: The program participants continue to face a multitude of barriers and challenges due to educational failures, limited economic self-sufficiency, and the economic downturn affecting the job market. The lack of employment opportunities and supportive services is much more evident for clients residing in the northeastern areas of Los Angeles County (Lancaster and Palmdale). In addition, consistent and systematic contact with the clients can be a challenge due to their unavailability for face-to-face visits and disconnected phone and cell numbers.

Action Plan: The program's coordinator continues to assist and motivate participants by presenting college enrollment information, including financial aid and educational grant applications. The coordinator assists youth with employment searches by working with Work Source and One Source Centers to assist the youth in employment readiness and employment opportunities. He networks at various employment conferences to obtain more information regarding services in the northeastern areas of the County.

Client Success Story: Client S is an 18-year-old who as a teen has been to Juvenile Hall several times which ultimately resulted in her removal from home. Due to the severity of her delinquent behavior, client S has been in three different placement programs. After aging out of the juvenile justice system, client S participated in a Transitional Housing Program for approximately a year. When she became pregnant, client S was forced to leave the Transitional Housing Program. With her desire to live on her own and take care of her child, she was accepted to the TTP. She now resides in her own apartment with her two-year-old daughter. She is currently enrolled in vocational training to become an office assistant.

DCFS – Moving Assistance for TAY

Successes: Overall, the program has been successful in helping to reduce the number of homeless Transition Age Youth. Unfortunately, success this quarter was affected by budget shortfalls. During this quarter 16 youth received rental assistance, three youth were newly approved. The program provided move-in assistance to three youth. The average expenditure was $852 per month.

Challenges: Challenges remained the same, in that youth continue to struggle with following through with timely submission of essential documents as well as maintaining stable contact numbers.

Action Plan: Based on funds availability, reassess funds and proceed to assist youth who have applied for assistance. Staff encourages maintenance of stable contact numbers.

Client Success Story: A former foster youth working part-time and attending school full-time, received rental assistance from DCFS and was able to devote more focus towards her studies at community college. As a result of her hard work and dedication, she was awarded and earned a 3.8 GPA. Her plans are to transfer to a four-year college, The University of Laverne or Loyola University.

III. PROGRAMS FOR INDIVIDUALS

9) Access to Housing for Health (AHH)

Goal: To provide clients discharged from hospitals with case management, housing location and supportive services while permanent housing applications are processed.
Budget: $3 million (Board Approved Funding)

Table C.1 : Access to Housing for Health Participants and Services
FY 2009-10, through June 30, 2010

(unduplicated count)	FY	Cumulative
Homeless Individuals	22	39
Chronic Homeless	18	107
Homeless Families	3	7
Female	20	64
Male	27	97
Transgender	-	1
Hispanic	6	33
African American	21	70
White	17	54
Asian/Pacific Islander	1	2
Native American	1	1
Other	1	2
15 and below	3	10
25-49	15	57
50+	29	95
Moving assistance	34	87
Housing (emergency/transitional)	42	149
Housing (permanent)	42	104
Rental subsidy	42	104
Eviction prevention	6	4

	FY	Cumulative
Education	3	5
Job training	7	8
Job placement	-	2
General Relief and Food Stamps	2	2
General Relief	3	63
Food Stamps only	-	1
Medi-Cal/Medicare	17	46
Section 8	38	46
Public Housing Certificate	6	16
SSI/SSDI	13	36
	FY	**Cumulative**
Case management	43	150
Health care	46	153
Life skills	43	150
Mental health/counseling	9	37
Substance abuse (outpatient)	1	17
Transportation	12	109
Alternative court	6	6
Social/community activity	16	16
Substance abuse (residential)	1	1
Recuperative care	1	1

Program Specific Measures (March 2010)	FY	Cumulative
Number of referrals	158	761
Number admitted to program (enrolled)	35	142
Pending applications (quarter)	15	-
Number who did not meet eligibility criteria	117	611
Number of exited clients	5	34
Reduction in Emergency Department visits (12 months post enrollment, n=69)	-	76%
Reduction in number of inpatient days (12 months post enrollment, n=69)	-	85%
Number of new AHH enrollees that have a primary healthcare provider	35	142

Transitional Housing/Case Management	
Average stay at emergency/transitional housing:	154 days
Case management (level 3)	
Average case management hours for each participant per month:	15 hours
Total case management hours for all participants during current reporting period:	795 hours
Number of cases per case manager:	13 cases

Table C.2: Longer-term Outcomes
FY 2009-10, Fourth Quarter

	6 mo.	12 mo.
Continuing to live in housing	80/82	51/53
Receiving rental subsidy	98%	96%
Case management	13	7
Health care	13	7
Mental health care	3	5
Substance abuse treatment	2	-
Reunited with family	3	1

Successes: AHH clients and graduates continue to participate in the monthly meetings which offer resources, health education and community/social supports. AHH continues to offer a weekly support group, which many clients attend on a consistent basis. AHH also has a Spanish biweekly group that clients participate in. These groups allow clients to meet other program participants, share resources and gain support. AHH continues to conduct individual therapy sessions and the participants have since made progress in therapy.

Last quarter, there were 69 AHH clients that had successfully maintained housing for one year in the program. They had a combined total of 297 Emergency Department visits during the 12 months prior to enrollment in AHH. After enrollment into AHH, the clients had a combined total of 70 Emergency Department visits. The number of Emergency Department visits was reduced by 76%. These 69 AHH clients also had a combined total of 587 inpatient days prior to enrollment in AHH. These clients had a combined total of 86 inpatient days after enrollment into AHH. The number of inpatient days was reduced by 85%.

Challenges: Some clients present with severe physical and/or psychiatric conditions and are unwilling to access treatment or comply with medication. Additionally, once clients are housed, some fail to attend monthly meetings or weekly group meetings and there is often a challenge in group participation and retention.

Action Plan: The AHH staff remains fully staffed. The housing locator continues to assist with the housing application; housing locator services and the move-in process are meeting clients' needs and occurring in a timely manner. The case managers and housing locator continue to work closely to best assist clients and ensure that they obtain and maintain permanent housing. The AHH staff continues to promote the program with current referral sources and the development of new ones. The staff plans to continue to reconnect with referral sources on a regular basis.

Client Success Stories: Ms. R is a 61-year-old African-American female who had been homeless for over a year prior to entering AHH. She resided in a transitional housing center while battling cancer. She has a history of stage IV gynecological cancer, which she continues to battle and obtains chemotherapy on a regular basis. She was diagnosed with cancer in 2008 and has had numerous failed treatments and radiation therapy since then. Since obtaining permanent housing in December 2009, she has started an experimental form of chemotherapy and she reports positive outcomes and improved health. She worked as a school teacher for 25 years and has authored books. Her interests include writing and reciting poems, one which she did during a monthly client meeting. Her case manager was able to assist her with obtaining In-Home Support Services and she took her own initiative to find furniture for her apartment and participate in a community cancer support group. As a result, her spirits and self-confidence have improved. Since obtaining housing, her appearance is less disheveled and is now well kept. She shows a lot of pride in her apartment by keeping it clean and inviting. She has been consistent with attending AHH appointments and monthly group meetings, and continues to tend to her medical care. Ms. R's health and mental health have significantly improved since obtaining permanent housing.

10) Benefits Entitlement Services Team for the Homeless (B.E.S.T.)
Budget: $2,000,000 (One-Time Funding)

Table C.3: B.E.S.T Services
FY 2009-10, December 1, 2009 – June 30, 2010

(unduplicated clients)	Cumulative		Cumulative
Homeless Individuals	50	Housing (emergency)	17
Chronic Homeless	348	Housing (transitional)	7
Transition age youth	16	Housing (permanent)	4
Female	126	General Relief and Food Stamps	3
Male	278	Section 8	1
		SSI	47
Hispanic	83	Transportation	1
African American	211	Medi-Cal/Medicare	19
White	97	Case management	395
Asian/Pacific Islander	7	Health care	395
Native American	3	Mental health care	341
Other	13	Recuperative care	21
		Substance abuse treatment (outpatient)	3
16-24	23	Case management (level 3)	
25-49	223	Average hours for each participant	5
50+	151	Total hours for all cases	730
*Ages of seven participants are not included.		Average caseload per case manager	40
Program Specific Measures			
Number of initial applications submitted to SSA			50
Number of initial applications approved by SSA			47
Average length of time from participant enrollment date to SSA approval date (days)			52

Successes: The Benefits Entitlement Services Team for the Homeless (B.E.S.T.) has done significant outreach to not only individuals who are on the streets and shelters but has also participated in several meetings as featured presenters throughout the County. These meetings have resulted in working directly with Rancho Los Amigos hospital onsite to provide B.E.S.T. services and also at the Multi-Service Center in Long Beach.

Challenges: One challenge in B.E.S.T. has been finding enough time from psychiatrists for the project. There are so many mentally ill individuals that need care and are in need of benefits.

Action Plan: No action plan is necessary at this time.

Client Success Story: Ms. H is a 54-year-old Caucasian woman with a degree with honors who was living out of a storage unit and using a bucket in lieu of a proper toilet. Prior to her homelessness and coming to B.E.S.T., Ms. H. worked in high level jobs with local governments and Fortune 500 companies. Ms. H was diagnosed with Chronic Post Traumatic Stress Disorder, recurrent, severe major depressive disorder, and Trichotillomania, along with alcohol dependence in full. It did not take very long until Ms. H had exhausted her savings. She moved out of her residence into her car, and later into a storage unit. Ms. H was referred from Detour Sober Living on Los Angeles' Westside.

At her first B.E.S.T. appointment, Ms. H was articulate and discreet, yet anxious, nervous, and emotionally fragile, she shared her 'life's fabric.' Her background was in stark contrast with other, more frequently heard ones, such as incarcerations, molestations, and economic blight. Ms. H's degree of commitment and mobility proved helpful. She was able to meet for signatures and last-minute appointments with the psychiatrist. Her case was processed and approved in 16 days.

The day came where mail from the Social Security Administration for Ms. H. arrived at the B.E.S.T. office in Bell; the typical envelope, in which the Social Security Administration sends out payments to individuals approved for benefits. Ms. H. received her initial check of over $ 11,000. Her words to the B.E.S.T. Project: "You've saved my life."

11) Center for Community Health Downtown Los Angeles
Budget: $186,000 ($76,000 expected for Ongoing Funding)

Table C.4: Center for Community Health Downtown Los Angeles (CCH)
FY 2009-10 through June 30, 2010

(unduplicated clients)	FY		FY
Homeless Individuals	5,824	Housing (emergency)	51
		Housing (transitional), average stay 90 days	71
Female	1,428	Housing (permanent)	103
Male	4,396	Rental subsidy	1
Hispanic	1,249	General Relief and Food Stamps	16
African American	3,006	Medi-Cal/Medicare	19
White	1,131	Section 8	12
Asian/Pacific Islander	219	SSI/SSDI	39
Native American	31	Case management	574
Other	775	Health care	5,824
More than one race/ethnicity may be selected		Mental health care	244
		Recuperative care	1
16-24	240	Substance abuse treatment (outpatient)	10
25-49	2,411	Substance abuse treatment (residential)	3
50+	2,566	Transportation	17
*Ages of all participants are not included.		Other	88
Case management (level 3)		General Relief only	1
Average number of hours:	1	Food Stamps only	2
Total case management hours:	720	Job training/referrals	22
Number of cases per manager:	123	Education	2

Successes: On June 28, 2010, CCH marked its one year anniversary. The employees of JWCH, DMH, DPH and DHS have enthusiastically worked together as a team to integrate care and provide a Medical Home for clients in a patient-centered system of care environment. Patient satisfaction surveys have been very positive and there have been many success stories of patients receiving SSI and other governmental benefits, along with housing. Clients with diabetes and other chronic diseases have shown marked improvement in the control of their disease. The number of patients being seen and followed for HIV and mental health has also increased over the past year due to the integration of services at CCH.

Challenges: Despite the many successes at CCH, there is still much work to be done. Wait times and total cycle time has been a challenge and the cause is multi-factorial. Despite the increased availability of appointments and services, the no show rate is still around 45%. Case conferences have been a challenge due to the high volume of patients and high case loads of the social services staff. Integrating substance abuse into the individualized service plans continues to be a problem but is being addressed by staff from JWCH, DPSS, DMH, and Homeless Health Care Los Angeles (HHCLA).

Action Plan: The Clinical Services meetings will continue monthly to help identify and resolve clinical and operational issues discussed above. Additionally, leadership from the agencies involved will continue to meet to determine, discuss and suggest methods that can be tried to improve the efficiency and overall quality of care.

Client Success Story: The client success story involves an elderly male status post cerebrovascular accident (CVA) five years ago with residual cognitive impairment and communication difficulties who is being followed at CCH by DMH for major depressive disorder. This patient was recently referred to the CCH medical social worker by the DMH psychiatric social worker for assistance in navigating the specialty care clinics at LAC-USC Medical Center. The patient was also diagnosed with prostate cancer around a year ago and had been treated and followed at LAC-USC by the specialty clinic (urology). Around the time of diagnosis of the prostate cancer the patient was also found to have multiple swollen lymph nodes, suggestive of possible lymphoma. A biopsy was recommended and the patient was referred to primary care for follow-up and a preoperative evaluation. However, when the CCH medical social worker escorted the patient to a medical appointment at the medical center, it was discovered that the preoperative exam and biopsy was never done. At that appointment the provider indicated he would write referrals for both and said the patient would receive appointment dates in the mail. After a few

weeks went by and the patient had not received appointments, the DMH and CCH staff got together and called LAC-USC to make an inquiry and the patient was finally given a definitive appointment date and time. In the meantime, in order to expedite the biopsy, the preoperative exam was done by the primary care provider at CCH.

12) Co-Occurring Disorders Court (CODC)

Goal: Assist dually diagnosed adult defendants in receiving comprehensive community-based mental health and substance abuse treatment.
Budget: $200,000 (HPI On-going Funding; pass through for DMH)

Table C.5: Co-Occurring Disorders Court (CODC) Participants and Services
FY 2009-10, through June 30, 2010

(unduplicated count)	FY	Cumulative		FY	Cumulative
Chronic Homeless	28	94	Education	3	18
Homeless Individuals	20	25	Job training/referrals	25	51
Transition Age Youth	3	4	Job placement	8	9
Female	22	64	CalWORKs	1	2
Male	29	60	General Relief (GR,FS)	5	19
			General Relief	6	6
Hispanic	4	12	Food Stamps only	1	4
African American	37	94	Medi-Cal/Medicare	-	32
White	9	14	SSI/SSDI	14	44
Asian/Pacific Islander	1	1	Shelter Plus Care	-	5
Other	-	2			
16-24		7	Alternative court	63	108
25-49		74	Case management	60	105
50+		41	Health care/medical	60	83
			Life skills	60	101
Eviction prevention	-	2	Mental health/counseling	60	105
Housing (emergency)	-	8	Social/community activity	37	57
Housing (transitional); avg. 65 days	10	57	Substance abuse (outpatient)	8	81
Housing (permanent)	10	12	Substance abuse (residential)	44	71
Rental subsidy	28	61	Transportation	41	98
Moving assistance	-	2	Clothing/hygiene	40	77
Longer-term outcomes (six or more months)					
Continuing to live in housing					15
Receiving rental subsidy					15
Enrolled in educational program, school					3
Obtained/maintained employment					8
Case management					71
Health care					71
Good or improved physical health					46
Mental health/counseling					71
Good or improved mental health					57
Substance abuse treatment (outpatient)					32
Substance abuse treatment (residential)					39
No drug use					55
Reunited with family					3
Emergency housing/Case management					
Case management (level 3)					3 hours
Total case management hours for all participants during current reporting period:					202 hours
Number of cases per case manager:					7 cases

Successes: Since the CODC program's inception in April 2007, 21 clients have graduated from the court program. All have had their active court case(s) dismissed. Another five clients are expected to graduate in August 2010. CODC graduates now have the option of attending a special Alumni Group developed by a SSG Consumer Employee to provide continued support to the graduates as they move forward in their recovery. The Alumni Group has expressed its excitement about staying connected with their peers and the SSG treatment team. As a way of giving back, the Alumni Group is working towards developing mentoring supports for new CODC clients.

In May, DMH granted SSG the flexibility to allocate all of its 62 Full Service Partnership (FSP) slots to the CODC program. This has resulted in an increase of eight FSP slots. Accordingly, the CODC team continues to focus its concerted efforts on client outreach, legal screening, and mental health screening and assessment in order to maximize utilization of the FSP slots and serve as many CODC clients as possible. While the Public Defender continues to generate a majority of the referrals for the CODC program, the District Attorney, Alternate Public Defender, bench officers, the Sheriff, and DMH's Jail Linkage staff have also contributed to client referrals. All CODC clients experience severe and persistent mental illness, including bipolar disorders, schizophrenia/psychotic disorders, depressive disorders, or anxiety disorders. In addition, all of the CODC clients struggle with drug and alcohol addiction, with over half reporting dependence on multiple substances, including crack, amphetamines, heroin, and alcohol.

The Antelope Valley Rehabilitation Center (AVRC) component of the CODC program has graduated thirty-seven clients from the 90-day residential co-occurring disorders treatment program. To further enhance treatment services, AVRC has implemented the evidence-based "Matrix Model of Intensive Outpatient Treatment." The Matrix Model integrates cognitive-behavioral therapy, contingency management, motivational interviewing, 12-step facilitation, family involvement, and other elements to give clients the skills and understanding they need to overcome addiction. The Matrix Model is expected to increase the amount of treatment and structure provided for the clients, thus preparing them for the "Step Up" phase of treatment following the completion of the AVRC program.

Project Employ -- funded by a Department of Justice/Bureau of Justice Assistance grant -- officially launched on June 1, 2010. Project Employ is designed to provide intensive employment supports and services to the CODC clients during their enrollment in the CODC Program. Thus far, 29 clients were accepted into Project Employ. Among those accepted, 12 interviews were conducted and five part-time jobs were obtained. Four of the clients continue to be employed as a forklift operator, a masseuse, a day laborer, and a telemarketer.

Finally, members of the CODC team traveled to Boston, Massachusetts, to take part in the National Association of Drug Court Professionals 16th annual training conference. The CODC team presented a workshop session on the CODC program to conference attendees from across the nation.

Table C.6: Program Specific Measures	FY	Cumulative
Number of clients screened for enrollment	232	636
Number of clients accepted for observation	55	133
Total number of clients enrolled	36	101
Number of clients pending enrollment (quarter)	24	-
Number of clients not meeting Program criteria	122	312
Number of clients rejecting/dropping out prior to enrollment	50	149
Number of clients lost during follow-up process	5	13
Number of participants in ER/crisis stabilization while enrolled in program	15	36
Average length of hospital stay (days)	5	-
Number of participants who have a primary healthcare provider while enrolled	31	84
Number of participants with new arrest(s)	20	51
Misdemeanor:	3	6
Felony:	17	31
Number of participants in jail	20	41
Average number of days in jail.	51	(FY 08-09) 25

FY 2007-08 average number of days in jail: 36

Challenges: In order to create additional pathways for prospective clients to access and benefit from the CODC Program, the CODC team is exploring plans to expand outreach to other criminal courts throughout the County. While all CODC clients are provided with emergency or transitional housing during their enrollment in the CODC program, only a small percentage of clients have been able to secure permanent housing. DMH and SSG continue to collaborate with housing providers in the downtown Los Angeles area to increase the clients' access to permanent housing options.

Action Plan: The CODC program's mental health provider, SSG, continues to collaborate closely with the Countywide Criminal Justice Coordination Committee (CCJCC) on grant writing to access additional

funds for enhancing and expanding CODC program services. In April 2010, CCJCC submitted an application for the Second Chance Re-Entry Grant that would provide funding for risk/case management evaluations and a Peer Mentoring Program. CCJCC has also nominated the CODC program for the County's 24th Annual Productivity and Quality Awards Program. An announcement regarding award recipients is expected in September 2010.

Client Success Story (by client): "My name is E. I've been on Skid Row since January 1980. This is where my life took a turn for the worse. I began not just selling drugs but using them also. Today, most of the people that I know have either moved on or gotten locked up or died. I have been one of the lucky ones that are still around on Skid Row. I began seeing life for what it is and put away some of the things that I was doing, but still was straddling the fence. In 1995, I was arrested for possession of cocaine. I was sentenced to six years state prison. I was released in 1998 and returned to my addiction. I entered a program for two years, found a job, and life was great. Soon after, I became disconnected to the process of recovery and returned again to my addiction. This went on for many years until March 2009. I was re-arrested for possession. During this period, I was receiving help for my depression. This is how I ended up in my current program -- a dual diagnosis program called Special Service for Groups and the Department of Mental Health through the courts. They not only work with me on my mental issues but they also help me with my addiction and my homelessness. I recently completed another program called *Avenues to Work* while still committed to my mental health program. I am well on my way back to that great life that I once knew."

13) DPSS General Relief (GR) Housing (Rental) Subsidy and Case Management Project

Goal: To assist the homeless GR population with a rental subsidy. In addition, coordinate access to supportive services and increase employment and benefits to reduce homelessness.

Budget: $4.052 million (HPI On-going Funding)

Table C.7: DPSS GR Housing Subsidy and Case Management Project Measures
FYs 2008-09 and 2009-10, through June 30, 2010

			Cumulative
Chronic Homeless	975	Education	35
Homeless Individuals	2,037	Job training/referrals	771
		Job placement	264
Female	1,174		
Male	1,838		
		SSI/SSDI	291
Hispanic	371	Section 8	6
African American	1,996	Veteran's	1
White	554		
Asian/Pacific Islander	44		
Native American	22	Case management	3,395
Other	25	Health care	930
		Life skills	519
16-24	334	Mental health/counseling	805
25-49	2,025	Substance abuse (resident)	21
50+	653	Substance abuse (outpatient)	152
	Cumulative	Transportation	1,066
Rental (housing) subsidy	3,395	Recuperative care	3
Moving assistance	2,472	Social/community event	1

Longer-term Outcomes (point in time)	**6 mo.**	**12 mo.**	**18 mo.**
Receiving rental subsidy	407	264	238
Obtained employment	5	2	-
Maintained employment	20	5	-
Enrolled in educational program, school	9	-	-
Case management	407	264	238
Health care	33	17	28
Mental health/counseling	20	30	25
Substance abuse treatment (outpatient)	13	2	16

Table C.8: DPSS GR Housing Subsidy and Case Management Project Measures
FY 2009-10, Fourth Quarter

	Fourth Quarter	**To date**
Number of applications received	201	2,901
Average number of business days to approve	20	-
Average amount of rental subsidy	$292	$292
Number of individuals re-entering program	22	165
Number of SSI approvals	35	279
Percent of SSI approvals (for FY)	4.35%	(FY 2008-09) 7.94%
Number of individuals disengaged from program	172	1,151
Case management (level 3)		
Average case management hours for each participant per month:		5 hours
Total case management hours for all participants during current reporting period:		3,992 hours
Number of cases per case manager:		74 cases

Successes: During this quarter, there were 35 SSI approvals. An evaluation study of the pilot's outcomes showed that the average length of stay for participants in the pilot program was about seven months. Compared to a control group, employable participants enrolled in the pilot project were two times more likely to find jobs. The total number of active subsidies for the last month of the quarter was 887, which is 18 short of the maximum allotment.

Challenges: Participants were relocating or moving out of their rental units without notifying the case-carrying Eligibility Worker or the GR Housing Case Manager (GRHCM), and their rental subsidies are

issued to their previous landlords which created more work for staff recouping the money from landlords and processing the documentation from the new landlord in a timely manner.

Action Plan: The following were the recommended actions:

- Staff to explain and remind the participants of their reporting responsibilities;
- Encourage participants to provide valid contact numbers; and
- Staff to increase the frequency of contacts with participants to a minimum of twice a week.

Client Success Stories:

Ms. M applied for GR and Food Stamps in September 2009. In November 2009, she was diagnosed with a mental health disorder. In December, she applied for the Housing Subsidy Project and was placed in a rental housing unit in January 2010. Ms. M was provided supportive services and extensive case management so she could attend all of her appointments and assessments as well as treatment services. She filed a SSI application, and in May 2010 she received her first SSI check. She was very thankful to the Lancaster GRHCM for all of the assistance, hard work and encouragement provided to her.

Mr. G applied for GR benefits in October 2008. He was enrolled in a drug rehab program, which he successfully completed in three months. In October 2009, he applied for SSI benefits with the assistance of the DPSS SSI Advocate. He was also placed in the GR Housing Subsidy Project. In April 2010, he was approved for SSI benefits.

14 and 15) Homeless Release Projects (DPSS-DHS and DPSS-Sheriff)

Goal: Identify individuals scheduled for release who are eligible for DPSS administered benefits.
Budget: DPSS-DHS: $588,000; DPSS-Sheriff: $1.171 million (On-going Funding)

Table C.9 Homeless Release	**Total FY**	**DPSS-DHS**		**DPSS-Sheriff**	
(unduplicated count) FY 2009-10, through June 30, 2010		**FY**	**Cumulative**	**FY**	**Cumulative**
Homeless Individuals	2,337	815	*1,131	1,522	*6,172
Female	735	70	159	665	1,409
Male	1,554	233	558	1,321	1,975
Transgender	2			3	8
Hispanic	739	87	210	652	1,195
African American	931	111	275	820	1,532
White	524	84	191	440	756
Asian/Pacific Islander	59	12	20	47	52
Native American	6	3	5	3	6
Other	36	6	16	30	52
16-24	398	9	27	389	667
25-49	1,504	169	389	1,335	2,247
50+	393	125	301	268	478
Housing (emergency)	119	56	131	63	281
Average stay (days)	12	14	-	10	-
CalWORKs (approvals)	13	1	2	12	62
General Relief (w/FS)	679	102	392	595	2,797
General Relief only	125	22	99	87	390
Food Stamps only	11	1	6	10	59
SSI/SSDI	31	-	-	31	56
Veterans' benefits	7	-	-	7	13

*Demographic information not available for FY 2007-08. Cumulative demographic information includes FYs 2008-09 and 2009-10.

Table C.10 Program Measures	Cumulative Total	DPSS-DHS		DPSS-Sheriff	
		FY	Cumulative	FY	Cumulative
Total referrals received	11,466	356	1,168	2,422	10,298
Total referrals accepted	7,252 (63%)	131	555	1,165	6,697
Of the total referrals accepted:					
Total approved	921 (FY)	129	*262	792	3,438
Total denied	168 (FY)	32	*218	136	269
Total pending release:	1,730 (FY)	2	-	1,728	-
Releases/discharges	1,047	65	304	610	743
Number of applications					
Food Stamps	492	69	70	403	422
General Relief	3,165	57	432	376	2,733
CalWORKs	50	-	1	5	49

**Information not available for FY 2007-08.*

DPSS-DHS Homeless Release Project

Successes: Thirty-two individuals were discharged from the County facilities and received Food Stamps, General Relief or CalWORKs benefits.

Challenges: The private hospitals continued to have an extremely low number of referrals and only two approvals since the expansion to private hospitals on September 29, 2008.

Action Plan: Program staff has offered training to assist the private hospital staff on the use of the DPSS screening tool and is waiting for private hospital staff to respond to the Department's request.

DPSS-Sheriff Homeless Release Project

Successes: Priority list interviews done at Inmate Reception Center (IRC) rather than at Men's Central Jail attorney room has increased significantly. The priority list allows the Eligibility Worker (EW) to interview more inmates in less time.

Challenges: The number of referrals has increased. However, due to inmate court dates, Custody Assistant shift changes and lock downs, the inmates are being released before DPSS staff has a chance to interview them.

Action Plan: Program staff has discussed this issue with the County Sheriff's Department (LASD). However, court dates, lock downs and individuals being released directly from the court are beyond the control of the LASD staff.

16) Homeless Recuperative Care Beds

Goal: Provide recuperative care services to homeless individuals being discharged from County hospitals and assist participants with accessing transitional or permanent housing, ongoing health care, and other resources and supportive services.

Budget: $4.739 million (One-Time Funding)

Table C.11 : Homeless Recuperative Care Beds Participants and Services
FY 2009-10, through June 30, 2010

(unduplicated count)	FY	Cumulative		FY	Cumulative
Homeless Individuals	265	545	Housing (permanent)	34	79
			Housing (transitional)	58	130
Female	36	79	Housing (emergency)	12	51
Male	227	462			
Transgender	2	4	General Relief only	-	11
			Medi-Cal/Medicare	-	7
Hispanic	111	157	SSI/SSDI	-	7
African American	75	143			
White	62	112	Case management	265	545
Asian/Pacific Islander	4	6	Health care	265	545
Native American	3	3	Life skills	-	12
Other	10	27	Mental health/counseling	-	1
(race doesn't include two quarters; updating)			Recuperative care	265	545
16-24	-	4	Transportation*	-	70
25-49	129	268	Substance abuse (outpatient)*		2
50+	136	273			

Program measures	**FY**	**Cumulative**
Number of patients referred for recuperative care beds	366	722
Number of patients admitted to recuperative care services	265	545
Number of patients who were discharged from recuperative care services	248	526
Number of patients who were assigned to a primary health care provider during recuperative care stay	265	545
Average length of stay for patients in recuperative care program (days)	22	29
Percent decrease in ER visits 6 months after receiving recuperative care	-	28%
Percent decrease in inpatient admissions 6 months after receiving recuperative care	-	70%

Emergency housing/Case management	
Average stay at emergency/transitional housing:	29 days
Level 3 Assisted/Supported Referral and Counseling case management services	
Average case management hours for each participant per month:	6 hours
Total case management hours for all participants during current reporting period:	480 hours
Number of cases per case manager:	25 cases

Successes: The Recuperative Care program served 545 new unduplicated individuals to-date, from April 2008 through June 2010. At the end of the previous quarter for FY 2009-10 (March 31, 2010), a six-month pre- and post- analysis was conducted on the participants served who received recuperative care services at least six months prior to the analysis. For these recuperative care participants, a pre-/post-comparison showed **a 28% reduction in ER visits and a 70% reduction in inpatient hospitalizations.** In addition, there was **a 47% decrease in the number of participants who utilized the ER and a 71% decrease in the number of participants who required hospitalization.**

Challenges: The most significant challenge continues to be the lack of available housing resources that clients can access upon discharge from recuperative care. Earlier in this FY, the provider had to reduce the number of transitional beds they operated due to the loss of private funding. In addition, a valuable permanent housing resource provided through County's HPI funding, DHS' Access to Housing for Health (AHH) project, stopped taking new referrals due to full utilization of their Section 8 vouchers. The reduction in accessible housing/placement resources significantly impacts efforts to discharge recuperative care clients into more stable housing environments. A majority of clients do not have a regular income source. Some clients are not able to access housing resources that have requirements on an applicant's incarceration and/or behavioral history or restrictions related to legal status which

present additional challenges. In addition to the lack of resources for the population served, the Recuperative Care program is a short-term service with most clients staying between two to four weeks. This does not allow much time to resolve the multiple housing placement issues facing clients. Given the use of manual data collection and reporting methods, various challenges in these areas continue, however improvements in data quality and reliability are progressing.

Action Plan: Both Recuperative Care sites have on-site access to benefits assistance for clients who may be eligible for SSDI/SSI through the HPI-funded homeless SSDI/SSI project, B.E.S.T. This project has been very successful in expediting the SSI application process. Clients are able to access stable income and increase their options for obtaining permanent housing. In addition, the B.E.S.T. team provides case management and primary health and mental health care that can follow clients beyond their short stays in the Recuperative Care program. Other efforts to link recuperative care services with permanent housing opportunities are continuing. Case managers are utilizing online resources, such as the County's housing resource database. Staff assists clients with reconnecting with their families, and the provider is experiencing increasing success. Although the AHH project is no longer taking new referrals at this time, staff will be contacted if the project is successful in securing additional Section 8 vouchers and funding. The recuperative care director has oversight responsibilities for program activities and is continuing to work on addressing the identified challenges, including development of a data collection system for these services. DHS staff will continue to meet with JWCH management staff to discuss program status and progress and provide assistance as needed. Improvements have been noted for data collection and reporting, however further progress is needed and DHS will continue to work with the program director.

Client Success Story: Client C is 43-year-old Latino male, who has been homeless for one year due to his girlfriend moving, leaving him unable to pay for their home. Consequently, he lost his home and employment. The client was initially referred to Recuperative Care at the Weingart Center by Rancho Los Amigos in January 2010. He was diagnosed with left-plantar ulcer, osteomyelitis, and a toe amputation. When he arrived, more than his financial depletion, he was emotionally empty from his upheaval. Prior to his admission into the program in November 2009, Mr. C. presented himself to LAC+USC emergency department and was admitted for further care. On his third admission to LAC+USC, evidence of osteomyelitis was confirmed and he was transferred to Rancho Los Amigos for rehabilitation. After treatment with IV antibiotics, the client was accepted into the program for assistance with dressing changes. An application to the AHH project was submitted about two weeks after he arrived at Recuperative Care. The client was approved for Section 8 housing with AHH, pending medical stability. Due to increase ambulation on a daily basis, related to travel to and from scheduled appointments, the client’s wounds were not improving and showed signs of infection. He kept his appointment with the podiatrist at Rancho in late February 2010, and was told that he would need to be re-admitted to the hospital. Per program protocol, the client was discharged from the program at that time.

In April 2010, Mr. C. was again referred to the program facility for osteomyelitis to his foot. Due to his recent discharge, the AHH representative requested more medical information and re-assessed the client's ability to perform consistent self-care in an independent living environment. He was seen at the by a nurse on a daily basis for taking vitals, daily wound care, self-performed blood testing, and self-administration of insulin. With consistent encouragement and guidance, he gradually demonstrated that he could independently treat and care for himself. In addition to his ability to help himself, he gained understanding of his treatments and a healthy attitude for his life. This was demonstrated by making his medical appointments, meeting regularly with the case manager, and following up on referrals for housing options and other public assistance. He was extremely pleased that his wound was finally healing, and his new attitude and knowledge of self care were coming together to improve his overall health. Mr. C. was deemed stable for discharge from the program. The AHH case manager was notified that the client was medically stable and he was discharged in May 2010 directly into temporary housing at the Coronado Hotel, while he awaits receipt of his Section 8 voucher. To ensure medical continuity, the client was linked to The Center for Community Health for primary health care, a diabetic case manager, and medication management. Additionally, he maintains follow-up appointments at Rancho Los Amigos. He continues to stay in touch with staff regarding his housing and medical updates, and informs of progress on his health and well-being. His outlook on life has completely turned around since he first arrived. His eagerness to return to work and further his formal education is simply contagious. Staff is thankful for the opportunity to have been a part of this gentleman's health and wellness team!

17) Housing Specialists - DMH

Goal: Assist homeless individuals, families, and transition age youth (TAY) to obtain and maintain permanent housing.

Budget: $923,000 (annually in MHSA Funding)

Table C.12: Housing Specialists Program Specific Measures

	FY 2009-10	FY 2008-09	FY 2007-08
Number of referrals to program	n/a	842	n/a
Number of property owners contacted	776	360 (QTR)	898

Successes: During the fourth quarter of FY 2009-10, the Countywide Housing Specialists, funded through the Mental Health Service Act (MHSA), initiated contacts with 397 homeless individuals and 48 homeless families with a mental illness. Based on these contacts, the Housing Specialists provided a variety of housing related services including the following: 47 individuals received assistance with finding permanent housing; 61 individuals were referred to an emergency shelter funded through DMH; and 171 were assisted with moving into transitional housing.

DMH was approved to utilize Phase 28 funds from the United Way of Los Angeles for the Emergency Food and Shelter Program in the amount of $62,000. These funds have been provided for food ($22,500) and hotel vouchers ($39,500). This supplements the existing Housing Assistance Programs funded through the MHSA and the Projects for Assistance in Transition from Homelessness (PATH) grant. These resources will be available in eight Service Areas, providing food and motel resources to DMH clients and individuals experiencing a financial crisis in the directly operated clinics.

Table C.13: Participants and Services
FY 2009-10, through June 30, 2010

	FYs 2008-09 and 2009-10	FY 2007-08
Chronic homeless individuals	79	-
Homeless individuals	2,186	2,343
Homeless families	188	255
Transition age youth	17	142
Demographics not provided for all participants in families		
Female	1,345	*n/a
Male	1090	
Transgender	16	
Hispanic	861	
African American	717	
White	618	
Asian/Pacific Islander	60	
Native American	17	
Other	130	
15 and below	15	
16-24	11	
25-49	4,173	
50+	30	
	FY 2009-10	**Cumulative**
Moving assistance	200	342
Eviction prevention	35	40
Housing (emergency)	1,260	2067
Housing (transitional)	649	952
Housing (permanent)	507	824
Rental subsidy	154	244
Section 8	215	*215
Shelter Plus Care	19	19
Mental health	681	*681
Life skills	468	468
Residential management	1,015	1,015

*Information not available for FY 2007-08.

The Adult Justice, Housing, Employment and Education Services Bureau in partnership with the Corporation for Supportive Housing (CSH) co-sponsored the Third Annual Housing Specialist Training Institute entitled *Restoring Hope and Resiliency through Permanent Supportive Housing*. The Institute, which was held at the California Endowment on June 14 and 15, 2010 was attended by approximately 200 individuals, including housing specialists and other staff who provide housing services. The Institute provided information and training on quality housing services that promote hope and support as well as wellness and recovery.

Challenges: The Department is continuously challenged with assisting target populations in identifying affordable housing options with limited or no income. DMH relies on rental subsidies provided through contracts with the Housing Authority of the City of Los Angeles (HACLA) and the Housing Authority of the

County of Los Angeles (HACoLA) to access private rental housing. The Department is currently expecting 99 Good Samaritan Grant Sponsor-based certificates from HACoLA for individuals who are chronically homeless. Forty-four tenant-based Shelter Plus Care certificates are expected to be awarded by HACLA before the end of the year. For the homeless Section 8 Program, HACLA has begun to interview individuals who had previously applied but had been placed on a waiting list. HACLA expects to issue vouchers to those who can verify their homeless status.

Action Plan: The Department in collaboration with other departments will continue to work diligently to identify affordable housing to address the housing needs of the low and very low income population which DMH serves. The Department will continue to apply for rental subsidies offered by the local housing authorities; pursue affordable units offered through affordable housing developers; and facilitate the development of a roommate match network. In addition, DMH through the MHSA Housing Program has committed capital development funds and capitalized operating subsidies for 29 local housing projects. These projects will create a pipeline of approximately 728 new affordable housing units for individuals with mental illness and a total of 1404 units overall. Two of these projects are currently open and four have begun construction.

Client Success Story: In February 2009, Client A became homeless for the first time after raising eight children as a single mother. Her Supplemental Security Income (SSI) benefits were suspended due to an 11-year-old warrant which surfaced at the time of her recertification for SSI benefits. Client A was evicted after being stable in her apartment for 10 years. As a result of homelessness, she lost everything including her furnishings, clothes and family support. Under extreme stress of being homeless, her mental health symptoms increased causing relapse. She reported frequent thoughts of doing harm to herself. Her therapist and case manager at the DMH West Central office in Service Area 6 intervened and provided her with supportive services to address her housing and psychiatric needs. She was referred to an emergency shelter where she stayed for 14 months and was also hospitalized for kidney complication. After stabilization, the case manager and the housing specialist continued to provide support to secure permanent housing. She was provided with housing leads and was accompanied on housing interviews. Just before her 60th birthday in April 2010, she was accepted at A Community of Friends low income apartments in Compton where she is currently paying 30% of her General Relief payment until her SSI is re-instated. She has since been reunited with her children and grandchildren.

18) Just In-Reach Program

Goal: Engage homeless nonviolent inmates upon entry into jail. Develop a release plan that coordinates an assessment and links clients to supportive services, benefits, and housing options upon their release. Case management team works with clients to obtain employment and explore rental subsidy eligibility.

Budget: $1,500,000 (One-Time Funding)

Table C.14 : Just In-Reach Program
FY 2009-10, through June 30, 2010

	Cumulative		Cumulative
Homeless Individuals	293	Housing (emergency)	15
Chronic Homeless	387	Housing (transitional)	169
		Housing (permanent)	104
Female	172	Moving assistance	73
Male	338	Rental subsidy	13
		Eviction prevention	3
Hispanic	138	Life skills	66
African American	225	General Relief (and Food Stamps)	92
White	178	General Relief only	76
Asian/Pacific Islander	14	Food stamps only	48
Native American	3	SSI/SSDI	40
Other	51	Veterans' benefits	29
(not for all participants)		Case management	555
		Health care	42

16-24	103	Mental health care	37
25-49	526	Substance abuse, outpatient	54
50+	102	Substance abuse, residential	81
		Transportation	148
Job training	484	Legal advocacy	167
Job placement	97	Social/community activity	44
Education	115		

Program Specific Measures	**Cumulative**
Number of participants who received intake/enrollment	532
Number of participants who received intake/enrollment within 72 hrs of initial interview	362
Number of participants who did not complete program (exited prior to completing)	130
Number by violent crime	139
Number by non-violent crime	395
Number by area of residence prior to incarceration (most frequent residence)	370
Number by area of residence prior to incarceration (second most frequent residence)	60
Number of times in County jail	682
Number of times in State prison	115
Number of participants with a service plan	1,982
Number of participants with a service plan within a week from intake/enrollment	1,954
Number of referrals provided to participants by type:	
- Service(s): Case management, health/medical care, mental health, substance abuse treatment, transportation, and mentoring	347
- Benefit(s): CalWORKs, General Relief, Food Stamps only, Section 8 and/or Shelter Plus Care, SSI/SSDI, Medi-Cal, Veterans	285
- Job/education related service(s): Job training, employment referrals, education	544
Number of participants who do not return to jail	405

Emergency housing/Case management	**Quarter**
Average stay at emergency/transitional housing: (11 participants)	98 days
Case management (level 2)	
Average case management hours for each participant per month:	3 hours
Total case management hours for all participants during current reporting period:	1,404 hours
Number of cases per case manager:	36 cases

Longer-term outcomes (6 or more months) FY 2009-10, Third Quarter	
Maintained permanent housing	50
Obtained employment	8
Maintained employment	8
Enrolled in educational program, school	10
Case management	153

Successes: Clients had a recidivism rate that averages about 34% through the first 21 months of the program. Compared to the County jail population's recidivism rate of 53% during a similar time frame, this is significantly lower. The program has been measured with similar, more established models in Chicago, New York and Washington, DC and measures up positively. The Just In-Reach program (JIR) has assisted in placing 199 homeless or chronically homeless inmates into transitional or permanent housing during the program year. With partnerships with other agencies, the JIR program has contributed directly toward move-in costs for permanent housing. After housing placement, staff continues to work with clients to provide them the necessary supportive services to continue their success.

Challenges: The housing staff encounters significant challenges such as limited units and overbearing requirements. The disqualifications for public-assisted housing occur all too often which guides staff toward private landlords. The biggest barrier with the private landlords is the credit check. JIR employment specialists have had difficulty placing clients into jobs. Most of JIR clients report not having any history of employment. Coupled with the current state of the job market, JIR staff relies heavily on existing and new employer relationships to place the clients. Clients are also given incentives such as clothing and transportation passes for their job search. Once the client is placed, intensive follow up continues with the client to aid them in adapting to new circumstances.

Action Plan: JIR established a Landlord Advisory Board in an effort to create more housing opportunities for clients being released from jail. Private property owners and public housing providers are brought

together in regular meetings for informative sessions that have been able to ease concerns to landlords about the population JIR serves. Current landlords of JIR clients voiced their positive opinions on how the program is able to support individuals to live independently. The Sheriff's Department participates in these meetings. Moreover, JIR increased incentive plans for participants by offering transportation and store credits for simply returning for a case management session post release. As a result, this has expanded to job search and housing placements.

Client Success Story: Client M, a 47-year-old Hispanic of Puerto Rican descent, used drugs and had been in and out of County jail and prison since the age of 16. Last arrested in June 2008, he completed the Merit program at South Facility (Pitchess Detention Center) and was court ordered to Tarzana Treatment Centers for one year, which he completed last February. Currently, the client has been residing at Tarzana's Transitional Housing program in Reseda. He has secured full-time permanent employment at Micro 2000 and is currently in the process of securing his own private apartment. JIR has approved the move-in costs and lease so the client can move into his own apartment by May 1st. He has remained focused throughout this whole process and has not lost sight of the importance of his sobriety by maintaining his support network, Alcoholics Anonymous (AA) meetings, individual counseling, etc. The client's schedule consists of a daily routine which begins at 3:30 a.m. so that he can commute by bus to be at work at 6:00 a.m. He attends meetings/groups from 5:00 p.m. to 9:00 p.m., and his curfew is at 10:00 p.m. This client has been able to stay focused on his goals with the help of JIR support services.

19) Long Beach Housing Now – PATH Ventures
Budget: $300,069 (Board Approved Funding)

Table C.15 : Long Beach Services for Homeless Individuals
FY 2009-10, through June 30, 2010

	Cumulative		Cumulative
Chronic Homeless	10	Moving assistance	10
		Rental subsidy	8
Female	3	Housing (transitional)	10
Male	7		
		Case management	8
Hispanic	1	Heath care	3
African American	1	Mental health care	1
White	8	Social/community activity	8
		Transportation	8
25-49	4	Life skills	8
50+	6	Food	1
		Utility assistance	1
Job placement	1		
CalWORKs	1		
Food Stamps	1		

Case management (level 2)	Quarter
Average case management hours for each participant per month:	4 hours
Total case management hours for all participants during current reporting period:	120 hours
Number of cases per case manager:	10 cases
Longer-term outcomes (six months)	
Continuing to live in housing	2
Receiving rental subsidy	2
Obtained employment	1
Maintained employment	1
Case management	1
Health care	1

Successes: One challenge at the start of the program was convincing landlords to work with staff. When landlords now have a vacancy, they call staff first. The landlords stated that if they have a concern, staff responds quickly and almost always finds a satisfactory resolution. Overall, landlords feel that the rent is paid on time every month, the tenants are polite. Moreover, the landlords believe that they are helping to take people off the streets.

Challenges: As each client moves into housing, one of the first steps is to determine how their income can be increased to a level that will allow them to live independently after the rental subsidy ends. If the client is interested in working, staff helps them with their job search. For most clients, applying for SSI is their best option. The application process for SSI can be long and labor intensive for the client. Often much of the required documentation, like birth certificates, has been lost after years on the street, and a missed appointment can bring the entire process to a halt. The case manager works closely with the client to ensure that documentation is turned in and appointments are attended.

Action Plan:

- Apply for SSI benefits or increase income through employment
- Connect the clients with medical/mental health providers
- Increase skills through training or education
- Work with clients on life skills required for independent living (budgeting, money management, housekeeping, and other tenant responsibilities)
- Connect clients to community resources and support systems

Client Success Story: Client R was homeless for five years prior to moving into housing in December. Once she was housed, she applied to be an in-home care provider. Although the application and approval process took almost three months, she persevered and started working in April. With the help of this grant, program staff purchased four pairs of scrubs for her to wear to work. Since April, she has been working three days a week, for a total of 30 hours a month. She enjoys her job.

20) Long Beach Services for Homeless Veterans

Goal: Assist veterans with housing, employment, SSI/SSDI, and legal issues such as child support. The program provides case management, outreach, and mental health services.

Budget: $500,000 (Ongoing Funding)

Table C.16 : Long Beach Services for Homeless Veterans
FY 2009-10, through June 30, 2010

	Cumulative		Cumulative
Homeless Individuals	1,942	Education	11
Chronic Homeless	249	Job placement	11
Homeless Families	29	Job training	17
Female	225	General Relief (and Food Stamps)	23
Male	1,993	General Relief	6
Transgender	2	SSI/SSDI	23
		Section 8	1
Hispanic	340	Veterans' benefits	62
African American	892		
White	792	Alternative court	1
Asian/Pacific Islander	45	Case management	376
Native American	8	Health care	7
Other	143	Mental health	81
16-24	89	Substance abuse (outpatient)	5
25-49	1,037	Substance abuse (residential)	16
50+	1,094	Transportation	697
		Life skills	111
Eviction prevention	6	Social/community event	20
Moving assistance	55	Other	
Housing (emergency)	272	Credit repaired	72
Housing (transitional)	69	Legal services (referral)	11
Housing (permanent)	78	Driver license reinstated	40
Rental subsidy	18		

Program Specific Measures	Cumulative
Number of mental health coordination activities conducted	85
Number of mental health assessments provided to homeless veterans by MHALA	44
Number of meals provided to homeless veterans. (includes food/meal vouchers)	228
Number of homeless veterans whose child support payment was eliminated or reduced by SPUNK	82
Number of outreach sessions conducted by U.S. Vets and DHHS	57
Number of homeless veterans contacted through outreach sessions by U.S. Vets and DHHS	1,266
Number of outreach sessions conducted with veterans recently returning from tour of duty	5
Number of mental health educational pamphlets developed	6

Successes: The partners of the Long Beach Homeless Veterans Initiative (HVI) – City of Long Beach, Department of Health and Human Services (City), Mental Health America of Los Angeles (MHALA), Single Parent United N Kids (SPUNK), and United States Veterans Initiative (US VETS) – have completed the second year of providing a comprehensive outreach and service delivery program for homeless veterans. Since the start of the grant in 2007, HVI has reduced or eliminated nearly $2 million in child support arrears. Additionally, according to the *Cost Avoidance Yielded Through Participation in The Long Beach Homeless Veterans Initiative* study conducted by the County Chief Executive Office Research and Evaluation Services unit, in the first year of services, HVI provided an estimated $1.4 million in cost avoidance savings to these four departments within the County: DPSS, DHS, DPH, and the Sheriff's Department.

A significant factor in the success of HVI has been the collaboration, both within the HVI partnership as well as with other agencies in the community, to provide community education, outreach, and service provision. In April 2010, the City, US VETS, and MHALA participated in the Community Dialogue on Health and Homelessness event, which was hosted by the Center for Community Engagement at the California State University, Long Beach. This event provided opportunities to educate and open a dialogue with community members regarding issues and concerns related to homelessness in Long Beach. In addition, US VETS, the Department of Veterans Affairs (VA) Long Beach Healthcare System, and MHALA participated in the annual mental health and wellness event, hosted by the City Department of Health and Human Services. This event, which was held at Recreation Park on May 22, 2010, had over 50 agencies and 200 community members in attendance.

The street outreach collaboration between the City, US VETS, VA Long Beach Healthcare System, and MHALA has lead to increase engagement of homeless veterans and connections medical and mental health services. Through this outreach, MHALA provided 11 new veterans with mental health and case management services in the Homeless Assistance Program (HAP). Three of the 11 veterans are now receiving services directly from the VA. The HVI partners also continue to collaborate to provide housing to homeless veterans.

HVI partners work closely with the Long Beach Connections Initiative, a grassroots collaborative effort to identify individuals who are homeless and have at-risk medical and mental health conditions. Of the 74 veterans identified during the survey conducted by the Long Beach Connections Initiative in July 2009, 13 have been housed. In addition, networking efforts of the MHALA Veterans Coordinator has resulted in increased referrals to the Department of Housing and Urban Development-Department of Veteran Affairs Supportive Housing (HUD-VASH) program.

Through referrals from the other HVI partners and VA case managers, SPUNK has assisted veterans by closing 14 child support cases during the quarter, for a total of arrears savings of $261,341. By assisting veterans with resolution of outstanding child support cases, SPUNK not only helps veterans reduce their debt, but also to obtain employment, and obtain permanent housing. For example, since the start of the grant, SPUNK has helped 40 clients recover their driver's license.

Ongoing research of funding sources to expand available resources and services for homeless veterans also remains a top priority for the HVI partners. Currently the HVI partners are leveraging resources from the Homelessness Prevention and Rapid Re-Housing Program, Supportive Housing Program, HUD-VASH, and HOME program to provide permanent housing and other supportive services to HVI clients. Future funding sources that are being explored include: the State of California MHSA, the VA Supportive

Services for Veteran Families Program, and the upcoming Homeless Emergency and Rapid Transition to Housing Act.

Challenges: Even though the collaborative efforts of the HVI partners have resulted in an increased connection of homeless veterans to VA Healthcare programs, many veterans have been reluctant to access physical, mental health and social services through the VA Healthcare system.

Action Plan· The HVI partners will meet and communicate regularly with the VA Long Beach Healthcare system social work staff to address veterans' perception and accessibility issues related to the VA. In September 2010, a meeting is planned with the Long Beach VA social work staff and HVI staff to address collaborative needs and stigma issues.

Client Success Stories: Client A entered US VETS Veterans Reentry Program (VRP) after successfully completed the Veterans Village Recovery Center (VVRC) substance abuse treatment. Client is now sober, enrolled as a student at Long Beach City College, and awaiting approval of his HUD-VASH voucher application.

MHALA assisted another veteran who had been homeless since being released from prison in 2008. Through engagement and counseling services, Client B reconnected with his family in Kansas. Additionally, the client expressed renewed interest in gaining employment, learning money management skills, and utilizing VA mental health services in his hometown.

The City HVI street outreach staff connected with a Vietnam War veteran who had lived in the Long Beach wetlands since 1997. Due to a medical condition, Client C was blind in one eye. Through the collaborative efforts of the Long Beach Police Department Quality of Life unit and the City's veteran-specific street outreach worker, the client underwent surgery at the Long Beach VA medical center to restore his vision. With the assistance of the veteran-specific case manager at the City of Long Beach Multi-Service Center (MSC), the client obtained GR benefits, while he applies for SSI benefits. The client also entered Project Achieve, a transitional living program that will help him to progress towards attaining permanent housing.

21) Los Angeles County Homeless Court Program

Goal: Assist homeless individuals with clearing outstanding tickets, fines, and warrants upon successful completion of rehabilitation recovery programs for mental health, substance abuse and/or other issues.
Budget: $379,000 (On-going Funding)

Table C.17: Los Angeles County Homeless Court Program Participants
FY 2009-10, through June 30, 2010

	FY	Cumulative		FY	Cumulative
Homeless Individuals	1,188	2,376	Hispanic	285	566
			African American	608	1226
Female	438	840	White	230	461
Male	747	1,530	Asian/Pacific Islander	29	44
Transgender	3	6	Native American	11	17
			Other	25	62
Alternative court	1,094	2,260		0	0
Transportation	85	102	15 and below	-	-
Food card	216	216	16-24	140	236
Housing (emergency)	42	42	25-49	752	1520
Substance abuse (residential)	2	2	50+	296	620

Program Specific Measures	FY	Cumulative
Number of Los Angeles County Homeless Court motions received	2,842	6,231
Number of program participants whose qualifying motions are submitted to and filed by Superior Court, and resolved within 30 days of submission	2,765 97%	6,172 99%
Number of audited records in the Superior Court's automated case management systems (TCIS/ETRS) that are accurate	179 98%	326
Number of motions that are granted by Superior Court	2,703 95%	6,028 97%
Number of motions that are denied by Superior Court	3	8
Number of individual cases filed under the Los Angeles County Homeless Court	3,726	7,619
Number of participants whose applications are submitted to the Los Angeles County Homeless Court within 30-days of initial contact with participant	1,067	2,182
Number of participants that have Los Angeles County citations or warrants processed upon program completion	913	2,035
Number of participants who complete at least 90 days of necessary case management, rehabilitative, employment or mental health services before their first appearance in Court	1,094	2,254
Number of case managers who receive training on Los Angeles County Homeless Court benefits, application and eligibility requirements, and legal resources	975	1,640

Successes: Following the record number of Homeless Court applications received last quarter, the Homeless Court team submitted a record number of motions to the Superior Court this quarter thanks to the hard work and increased hours of Public Counsel's volunteers and staff. In addition to the new administrative assistant, the Homeless Court team was assisted by two interns, a paralegal and a pre-law student, who together volunteered over 40 hours per week. Another success this quarter was that the Deputy City Attorney who reviews and signs Homeless Court correspondence and motions trained one of her staff to assist her in reviewing Homeless Court cases. With this additional support, cases are reviewed and processed more efficiently, thus preventing a backlog of motions ready to be submitted to the Court.

Superior Court continues to build strong working relationships with newly and changing staff assigned to Public Counsel and the Los Angeles City Attorney, without interrupting the quality of service to the program's clients. The motions submitted continue to be processed within 30 days and will continue to be a priority with Superior Court Homeless Court Program staff. Although the number of motions received this quarter was significantly low, $63,400 in fines and/or fees were suspended by the court to allow clients to move forward with their lives.

Challenges: There have continued to be processing delays for Homeless Court cases from the City of Inglewood, some of which were submitted by the Homeless Court team for resolution as long ago as

November 2009. This jurisdiction is one of the few for which Homeless Court motions are not processed through the Central Arraignment Court, and thus far, the Homeless Court team has been unable to work out an agreement with the Inglewood City Attorney's Office to resolve the cases directly, rather than through the Public Defender's Office.

Another obstacle the Homeless Court team continues to face is limited office space that is not sufficient to accommodate the success and growth of the Homeless Court Program. While the program has increased its visibility within the community, resulting in more individuals benefitting from its services as well as more volunteers interested in assisting with processing applications, the Homeless Court team continues to work in a small office with limited seating, desk space and computer terminal access. In addition, there is inadequate storage space within the Homeless Court office for the hundreds of active files the team needs to access on a regular basis. Public Counsel continues to experience additional staff turnover this quarter, and as a result, the number of motions received by Superior Court have dramatically decreased. Further, they continue to experience difficulty in receiving resolutions for citations from the cities of Pasadena, Torrance, and Inglewood in an orderly manner.

Superior Court continues to receive motions that are incomplete and appear to not have been thoroughly reviewed for eligibility. As a result, motions are returned ineligible and not processed. Superior Court staff continues to work closely with Public Counsel to ensure motions are filed and processed in a timely manner and all eligibility and requirements are met.

Action Plan: The Homeless Court team continues to work with contacts in the Public Defender's Office to address the delays in resolving cases from the City of Inglewood. The team is hopeful that through communication with appropriate supervisors in the Office, processing of Inglewood motions will be improved. The Homeless Court team continues to be creative in its use of the limited office space available in the City Attorney's Office, but hopes that in the future, through support from the County, it will be possible to gain increased desk space and access to computer terminals, thus resulting in increased productivity. Public Counsel is addressing the challenges described above by hiring additional personnel to join the Homeless Court team and has actively recruited summer clerks to assist with working with its Homeless Court Staff.

Superior Court continues to work with Public Counsel to review workflow and eliminate redundant processes. All Homeless Court Program staff have been working together to decrease the average turnaround time from the point of receipt of a case by Superior Court to Public Counsel.

Client Success Story: Client X is a veteran who served in the U.S. Air Force. He had been homeless for two years and suffers from alcoholism. Although he had undertaken an extensive job search to put his information technology degree to use, due to the fact that he had two citations for failure to appear and no registration on his vehicle, his driver's license had been suspended and was unable to gain employment. Client X's case manager at the VA applied to Homeless Court on his behalf and his citations were successfully resolved. Client X has since been offered a full-time position with a telecommunications technology company out of state, where he will be compensated at $22 per hour.

Client A had been homeless for eight years and ended up in a Homeless Shelter. He and others in the shelter began motivating each other by singing and dancing. While going through the process of having their outstanding matters with the court resolved, they applied for the television show "America's Got Talent." Client A and others in the shelter went as far as being accepted to appear in the semi-final show. In June 2010, Client A had his citations/cases resolved through Homeless Court and is now pursuing his singing and dancing career.

22) Moving Assistance for Single Adults in Emergency/Transitional Shelter or Similar Temporary Group Living Program

Goal: Assist individuals to move into permanent housing.
Budget: $1.1 million (One-Time Funding)

Table C.18: Moving Assistance for Single Adults Program Measures
FY 2009-10, through June 30, 2010

(unduplicated count)	FY	Cumulative
Homeless Individuals	838	1,605
Number applications received	838	1,605
Moving assistance approved	248	438
Percent applications approved	30%	27%
Average days to approve	19	*
Average amount of grant	$556	**
***		
General Relief (w/FS)	452	614
General Relief only	50	50
Food Stamps only	78	87
Medi-Cal/Medicare	-	1
SSI/SSDI	59	79
Section 8	3	4
Shelter Plus Care	2	12
Veterans' benefits	137	137

	Cumulative
Female	470
Male	789
16-24	68
25-49	630
50+	504
Hispanic	170
African American	792
White	250
Asian/Pacific Islander	11
Native American	29
Other	7

Demographic information was not available for all clients during FY 2007-08.

* FY 2007-08 average was 20 days; FY 2008-09 average was 12 days.
**FY 2007-08 average was $575; FY 2008-09 average was $722.
***Cumulative data for benefit information only includes FYs 2008-09 and 2009-10.

Successes: The program maintained a steady increase in the number of referrals for this reporting quarter.

Challenges: To date, the program experienced a low number of approvals despite the increase in referrals.

Action Plan: This program ended on June 30, 2010. Program management notified community partners and DPSS staff.

Client Success Story: Mr. G, a homeless participant, had difficulty in getting a job because of his situation. Fortunately, Mr. G was referred to the Single Adults Move-In Program and was provided the security deposit to move into permanent housing. The move enabled Mr. G to search and apply for employment. He called his HPI Eligibility Worker to inform him that he has gone for several interviews and may be offered a permanent job soon.

23) Project 50

Goal: To move 50 of the most vulnerable, chronically homeless individuals off of Skid Row and into permanent housing.

Budget: $3.6 million (Board Approved Funding)

Table C.19: Project 50 Participants and Services
FY 2009-10, through June 30, 2010

(unduplicated count)	Cumulative		Cumulative
Chronic Homeless Individuals (ever housed)	68	Education	2
		Job training/referrals	3
		Job placement	3
Female	13		
Male	54	General Relief (GR,FS)	16
Transgender	1	General Relief only	9
		Food Stamps	-
Hispanic	7	Medi-Cal/Medicare	46
African American	52	Section 8	3
White	9	Shelter Plus Care	48
Asian/Pacific Islander	-	SSI/SSDI	46
Native American	-	Veterans	15
Other	-		
		Case management	68
25-49	25	Health care/medical	68
50+	43	Mental health/counseling	68
		Social/community activity	68
Eviction prevention	15	Substance abuse (outpatient)	20
Housing (emergency/transitional)	50	Substance abuse (residential)	14
Housing (permanent)	68	Transportation	46
Rental subsidy	68	Legal Services	11
Moving assistance	2		

Longer-term outcomes (at 18 months)	**Quarter**
Continuing to live in housing	52
Enrolled in educational program	1
Case management	39
Health care	39
Good or improved health	-
Mental health/counseling	39
Good or improved mental health	1
Substance abuse treatment (outpatient)	27
Substance abuse treatment (residential)	2
No drug use	14
Reunited with family	1

Case management	**Quarter**
Level 3 case management services	
Average for each participant per month:	5 hours
Total hours for all participants:	566 hours
Number of cases per case manager:	20 cases

Successes:

Housing retention rates:

- At 6 months: 37 total housed; 33 remained housed (or alt housed) – 89.2% retention rate
- At 12 months: 49 total housed; 42 remained housed (or alt housed) – 85.7% retention rate
- At 18 months: 59 total housed; 51 remained housed (or alt housed) – 86.4% retention rate
- At 24 months: 67 total housed; 54 remained housed (or alt housed) – 88.5% retention rate (6 participants passed away; all of whom were either housed or alternatively housed at time of passing)
- At 27 months: 68 total housed; 52 remained housed (or alt housed) – 83.9% retention rate

Program Specific Measures	FY	Cumulative
Number of participants who exited housing	4	10
Number of participants developing individualized treatment plans	39	68
Number of participants participating in a housing retention group	-	-
Number of Project 50 participants having arrests	4	22
Number of Project 50 participants having hospitalizations	4	19
Number of Project 50 participants having an emergency room (ER) visit	3	15
Number of Project 50 participants with increased income (i.e., due to SSI/SSDI, GR)	n/a	36

Since moving to the new Cobb Apartments, Project 50 has expanded to provide permanent supportive housing at the new building for 74 participants. Some Project 50 participants decided to remain in their housing (at the Senator and the Dewey). The Integrated Supportive Services Team is currently working to outreach and engage the new participants.

The goal for the project is for homeless participants to be sustained in permanent supportive housing. The project has also demonstrated that various County, City and non-profit agencies can work together as a team to make this project a success. As part of Project 50's continuing Community Re-integration efforts, participants have participated in community events, such as fishing trips to local beaches and visits to local museums. Participants are also actively seeking out and participating in other community-based events.

Challenges: Project 50 staff and participants are adjusting to their new environment. The team is outreaching to the new participants at the Cobb. The team continues to work with clients to resolve substance abuse, poor money management, and rental payment issues. A few Project 50 participants have passed away as a result of pre-existing medical conditions.

Action Plan:

- Encourage staff stability, explore development of a process group for participants to deal with loss;
- Explore development of more life skills groups;
- Develop housing retention groups to address rental payment and poor money management issues;
- Implement money management services;
- Continue intensive substance abuse interventions; and
- Explore and encourage employment and education

Client Success Story: One client with a history of chronic drug use has entered long-term residential treatment. She has been doing very well and will be transitioning to sober living once she completes her program and is planning to take classes at local community college in counseling.

24) Santa Monica Homeless Community Court

Goal: Assist homeless individuals with clearing outstanding citations, warrants, and misdemeanor offenses upon successful completion of mental health, substance abuse and case management.
Budget: $540,000 (Board Approved Funding); $31,000 for transitional housing

Table C.20: Santa Monica Homeless Community Court Participants and Services
FY 2008-09, Cumulative (February 2007 – June 2009)

(unduplicated count)	Cumulative		*Cumulative
Chronic Homeless Individuals	155	15 and below	-
		25-54**	121
Female	49	55+	34
Male	106	Housing (emer/trans)	66
		Housing (permanent)	26
Hispanic*	17	Rental subsidy	11
African American	34		
White	102	Alternative court	155
Asian/Pacific Islander	3	Case management (level 3)	148
Native American	1	Mental health	65
Other	15	Substance abuse (outpatient)	5
		Substance abuse (residential)	32

Program Specific Measures	Cumulative
Total number of clients who have enrolled in Program	155
Number who participate that have citations or warrants dismissed upon completion	118 (76%)
Number who receive an emergency shelter bed and remain for two weeks or longer	35 (53%)
Number who accessed psychiatric and/or mental health services, received their mental health services at a DMH facility within the six-month program period (February-June 2009)	24 (37%)
Number who enter residential treatment complete a substance abuse program of 90 days or longer	24 (71%)
Number of arrests for all Court participants that have been placed in an emergency, therapeutic, transitional or permanent bed (or some combination of bed-types) for 90-days or longer as compared to the 90 days prior to entering residential program	70% reduction
Number of permanently housed who continue to be housed after four months, or will still be housed at the end of the program periods (which may be less then four months after housing placement)	24 (92%)
Average length of stay in emergency housing:	14-160 days

*Latino is not categorized as a distinct race by Santa Monica Homeless Community Court.
** Age range is categorized differently by Santa Monica Homeless Community Court.

Successes: The most successful ongoing collaboration which the Homeless Community Court program is engaged in is its relationship with Edelman Mental Health Center. Every Thursday morning, the Edelman psychiatrist and social worker, provide in-office services at the St. Joseph Center Homeless Services Center and occasional outreach to Homeless Community Court clients. The primary benefit of this Edelman collaboration is giving clients easy access to psychiatric care, with medications administered at two area pharmacies. Given the limited mobility, organization and/or motivation of many Court clients, this is often a superior service option to conventional mental health clinics. Integrating these psychiatric services into the pre-existing relationship which clients have with their program Case Manager and Mental Health Specialist also provides context which can help overcome service barriers stemming directly from mental health symptoms. A secondary but lasting benefit of the Edelman collaboration is streamlining the eventual transfer of client services from in-office services at the Homeless Services Center to long-term mental health care at Edelman or other DMH facilities.

Exodus Full Service Partnership (FSP) has been another valuable collaborator with the Homeless Community Court Program. A dually diagnosed client referred to this program was rapidly entered into intensive services with an outreach case manager. Working in tandem with Homeless Community Court and Exodus staff, this client was able to access a full range of services including psychiatric care, substance abuse treatment, emergency shelter, and permanent housing at a sober living. The FSP's collaboration with Exodus Mental Health Urgent Care Center accelerated the client's access to mental health services and dealt with acute mental health situations. This collaboration has also contributed to St. Joseph Center's familiarity with the services offered by Exodus Urgent Care, benefiting the agency more generally. Building on the success of the Chronic Homeless Program (CHP), the program has

managed to link many CHP participants to the Court which has resulted in the removal of barriers and has allowed for the successful transition by clients to the next phase of their lives. Continued collaboration between service providers, police and fire has allowed the program to continue engaging clients in the field and seizing opportunities to refer them to the program, when it appears they will be receptive to services. The program's talented Public Defender is greatly appreciated not only by the Resource Coordinator but also by the service providers. She creatively strikes a balance between advocating for her clients and using her motivational interviewing techniques to help clients see the benefits of connecting to services.

Challenges: The voluntary nature of the program allows many of the most chronic, high users of police, fire and social services the opportunity to opt out of the program. These are the very people the program had wished to engage in services using the authority of the Court. Experience has shown that many of the most chronic homeless do not want to access services. Moreover, the voluntary nature of the program does not allow the program to use the authority of the Court to connect individuals to much needed resources, including: mental health, psychiatric, medical, substance abuse and monetary assistance programs – all of which can be barriers to stabilizing clients, housing them and helping them maintain their housing.

Action Plan: The Court will only accept participants cited with quality of life crimes – misdemeanors and infractions. The Court will not accept felons or sex offenders. The very nature of the crimes, misdemeanors and infractions, prevent the court from following participants for extended periods of time and result in citations being dismissed with limited client progress. Greater oversight by the Court could have a very positive influence on participants and result in better outcomes. Currently, participants average 2-3 court visits before their citations and warrants are dismissed. This impacts both substance abuse treatment and housing placements. Indeed, because of Case Management initiated by the Court, some individuals may achieve outcomes months after their exit from the program. Court participants would benefit from a more directive tone and more exact prescriptions from the Court. While this has improved, the program continues to need progress in this area. The court appointed psychiatrist linked with the program supports this change in tone of court orders, and feels that it would result in greater client success. Furthermore, it would lend more objective finality to the process, taking out a great deal of ambiguity for the client.

Table C.21: Santa Monica Homeless Community Court (transitional housing and services)
FY 2009-10, March – June 2010

Homeless Individuals	6	Housing (transitional)	6
Male	6	Job training	6
White	5	Job placement	2
Hispanic	1	Veteran benefits	2
24-49	3	Substance abuse treatment (residential)	6
50+	2		

Successes: While the chronically homeless are often resistant to substance abuse and recovery programs, CLARE connects with individuals at a time of crisis. CLARE engages in various forms of proactive preventative outreach to individuals at functions such as Homeless Connect Day, Health Fairs, VFC Homeless Outreach and other opportunities created by various partnerships. Following initial entry, referral procedures begin at assessment, where counselors determine each client's need for off-site services. CLARE provides bus tokens or van transport to off-site providers. Referral partners include: Edelman Westside Mental Health Center (Dept. of Mental Health); SAMOSHEL; Ocean Park Community Center; Common Ground; Venice Family Clinic; St. Joseph Center; Westside Food Bank; City of Santa Monica Human Services; CLARE Drug Court, and the Salvation Army. Furthermore, individuals recognize CLARE as a chance to participate in recovery programs that (in time) will lead to permanent housing and employment.

Challenges: It has been challenging for participants to stay in the program.

Action Plan: Staff continues to reinforce the benefits of staying in the program. CLARE's new DETOX/Primary facility will be opening shortly and CLARE expects this to be a major success in their continuing commitment to assist the chronically homeless.

25) Santa Monica Service Registry

A) Step Up on Second
Budget: $ 518,000 (Board Approved – Third District)

Table C.22: Step Up on Second, Santa Monica Service Registry
FY 2009-10, through June 30, 2010

(unduplicated clients)	Cumulative		Cumulative
Chronic Homeless Individuals	27	Moving assistance	20
		Housing (transitional), 38 day stay	16
Female	9	Housing (permanent)	17
Male	18	Housing (emergency)	5
		Eviction prevention	8
Hispanic	5	Rental subsidy	20
African American	5	Legal	5
White	15	General Relief with Food Stamps	1
Asian/Pacific Islander	2	Medi-Cal/Medicare	2
		Case management	26
25-49	13	Health care	11
50+	14	Life skills	26
		Mental health care	26
Job placement	1	Social/community activity	26
Job training	1	Transportation	26
Section 8	2	Substance abuse treatment (outpatient)	3
Shelter Plus Care	6	Substance abuse treatment (residential)	4
Supportive Housing Program (SHP) subsidy	1	SSI/SSDI	1
Education	1	Alternative court	3
Case management level 3			**Quarter**
Average hours per case:			7
Total number of hours:			561
Caseload per case manager:			7
Longer-term outcomes (six or more months)			
Continuing to live in housing			10
Continuing to receive rental subsidy			10
Case management			27
Health care			17
Good or improved physical health			17
Mental health care			8
Good or improved mental health			8

Successes: The Step Up HOME Team has provided assistance and support with moving 18 clients into permanent housing, three others have received their Section 8 vouchers and are searching for housing with assistance from the HOME Team and two are waiting to have vouchers issued. Due to the recent death of one housed client, 14 are still permanently housed in their own apartments and two have remained in transitional housing. Staff continue to assist one client with navigating the court system which has allowed him to be released to the community in favor of treatment. The team enrolled three clients into money management services at Step Up. The team continues to provide case management services to 23 active clients. Step Up has provided case management services to a total of 28 individuals since the start of the program. Program staff are currently active in outreach and engagement with a chronically-homeless resident and hope to have him enrolled soon.

Challenges: The clients of Step Up On Second's HOME Team struggle with mental illness (treated and untreated). This causes them to mistrust and resist efforts to guide them toward housing and health. Also many clients are substance abusers. This adds to their inability to focus on goals or care for themselves. Frequently, only through great effort and patience from the HOME Team can some of clients perform the following tasks: complete paperwork; make appointments; deal with the Santa Monica Housing Authority; present well to building managers; connect with members of the public; interact successfully with other tenants; make a budget with the help of the Money Management Team; and seek medical care. Along with finding housing, Step Up's HOME Team must help Clients maintain and retain their housing by building their life skills abilities which are often weak. Staff teach how to clean their homes and help stay ahead of their housekeeping. Some clients have to be taught to have good hygiene and must be

reminded to maintain themselves. Clients often put off washing their clothes so staff help them remember and sometimes transport them to the laundry. As clients do not have cars, they have difficulty bringing their groceries home. Staff teach them to buy a few things at a time and when necessary take them shopping. Due to the chronically homeless population this program serves, the time to assist participants in successful life change is significant. As demonstrated, it can take years to simply establish a rapport and relationship as the foundation for trust and change. Funding for this program will be ending this year and one challenge is to make certain sufficient resources are available to continue to assist the 30 participants as they move forward with housing and mental health treatment.

Action Plan: To address the challenge of the funding for this program ending, Step Up has been taking a pro-active approach. Staff have been building relationships and connecting participants to other mental health treatment options so services will continue after the end of the HOME Team. The program management is also leveraging existing City of Santa Monica services to absorb the remaining HOME participants and continue providing case management, housing retention and mental health services. In this way, Step Up will continue to serve all 30 HOME participants once the current funding has ended.

Step Up will continue to:
1. Provide support and education to clients to maintain and retain housing as a primary focus;
2. Provide education and assistance with Independent Living Skills, develop good relationships with property owner and neighbors and continue to locate resources in the community;
3. Process and complete Section 8 voucher applications for remaining clients;
4. Encourage enrollment into money management (to date eight have been enrolled); staff will continue to work with the clients with maintaining a budget to obtain or maintain housing;
5. Provide transportation and support to and from medical appointments, grocery shopping, laundry and court appearances;
6. Advocate for clients with the legal system and property owners when needed;
7. Locate and educate property owners and manager about the benefits of the Section 8 program; and
8. Build strong relationships with property managers who have accepted Section 8 clients.

Client Success Story: Client B is 63 years old and has been homeless on the streets of Santa Monica for six years. The HOME Team first made contact with her in November 2008. She informed the team that she was a Step Up member and had not utilized services in years. She was initially very open to return for services, but unwilling to follow through in lots of areas. The Step Up HOME Team discovered she had received a Santa Monica Section 8 voucher in the past and allowed it to expire and remained homeless. She has been using the voicemail and mail service at Chrysalis, receiving GR and food stamp benefits from DPSS, and receiving medication and counseling from Venice Family Clinic. On numerous occasions she had been in contact with the Santa Monica Police Department (SMPD) for trespassing while sleeping on private and public property. For a short time in 2009, she was sleeping inside at Daybreak Shelter after receiving a referral from the SMPD Homeless Liaison Team during one of her many contacts. She was unable to sleep in the shelter's dorm-type setting and returned to the streets. Step Up HOME Team offered her a referral to SAMOSHEL emergency shelter and she refused. Step Up continued to have outreach contact with the client for several months.

In July 2009, she stated she was ready to be housed. Step Up's Team completed Section 8 paperwork and requested supporting documents. Client B had difficulty in gathering the required paperwork and required assistance in completing this task. She had another contact with SMPD and failed to appear in court on citation. Step Up encouraged her to return to court and offered assistance in navigating this process. When she wanted to return to Texas after her case was cleared because her life was a mess, Step Up encouraged her to just follow through on her application for housing and she agreed. Step Up submitted her completed housing paperwork in August 2009, the client was approved for a voucher in November, and she moved into her own apartment in December of that year. Client B finally agreed to allow the Step Up HOME Team to accompany her to the Social Security Administration (SSA) office to research the benefits for which she qualifies. While at the SSA office, she was informed that she was eligible for retirement and survivor benefits. The client is now housed in a fully furnished, subsidized apartment, and she is receiving in excess of $900 a month in mainstream benefits and is able to sleep in peace.

25B) OPCC Safety Net (Access Center)
Budget: $660,000 (Board Approved, Third District)

Table C.23: OPCC Safety Net (Access Center)
FY 2009-10, through June 30, 2010

(unduplicated clients)	Cumulative
Chronic Homeless	54
Female	14
Male	40
Hispanic	4
African American	12
White	35
Other	3
25-49	21
50+	33
Housing (emergency)	36
Housing (transitional), avg. stay 20 days	10
Housing (permanent)	19
Rental subsidy	13
Moving assistance	14

	Cumulative
Section 8	10
SSI/SSDI	8
Shelter Plus Care	8
Job placement	9
Job training	4
Medi-Cal/Medicare	2
General Relief with Food Stamps	3
General Relief	3
Food Stamps	4
Alternative court	4
Case management	54
Health care	19
Mental health care	28
Substance abuse treatment (residential)	7
Substance abuse treatment (outpatient)	8
Food	20
Clothing	5
Transportation	26
Life skills	13
Recuperative care	1
Case management level 3	
Average hours per case:	341
Total number of hours:	1,024
Caseload per case manager:	11

Longer-term outcomes (six or more months)	
Continuing to live in housing	13
Receiving rental subsidy	12
Case management	41
Health care	12
Good or improved physical health	8
Mental health care	21
Good or improved mental health	12

Successes: By the end of the quarter OPCC Project Safety Net was successful in assisting a total of 19 chronically homeless individuals on Santa Monica's Service Registry in securing or maintaining permanent housing.

- To date, 24 individuals are temporarily or permanently housed and off the streets.
- Two individuals obtained permanent housing in an apartment during the quarter.
- Five clients currently remain in emergency/transitional housing in motel units or shelter.
- One client has her housing voucher and is conducting an apartment search, one client secured a housing voucher; additionally six new voucher applications are pending.
- Several clients accepted mental health treatment (medication). These challenging steps forward have set the groundwork for some of the most disabled clients to prepare for housing in the coming quarter.
- Twenty-one clients are being directly engaged and case managed from the street.

Challenges:

- Untreated mental illness is one of the most significant challenges in OPCC Project Safety Net. In addition to the challenges of suspicion, paranoia, alienation and fear of services and society in general, several of the mentally ill participants are initially unwilling, or unable to take medications consistently.
- Manifestation of untreated mental illness is an impediment to benefits establishment
- Without entitlements to pay for medications, clients are unwilling or unable to access DMH programs that could procure medications at no expense

- Substance abuse treatment programs also pose a challenge. Participants have a negative history with local treatment programs, causing resistance both on the side of the participant and that of the treatment facility. Also, participants often have medical conditions requiring medical detox beds not available in the local community, making placement difficult. Working with treatment facilities to solicit flexibility is an ongoing challenge.
- Lack of a variety of housing options.
- Supporting housed clients with special needs who require intensive life skills training is a significant challenge as more individuals become housed.

Action Plan:

- With the assistance and flexibility of the OPCC psychiatrist and clinician, individual plans are created for participants to begin medication therapy. Beginning with the psychiatrist gaining rapport on the street, he prescribes medication that can initially be purchased and works with staff to develop a plan that intensively supports the participant in administering the medication. After the initial prescription and the participant stabilizes, the team connects the client to psychiatric urgent care to access medication in the DMH system.
- OPCC accesses treatment services for participants outside the area, based on the participants needs. Individual advocacy plans are developed, such as proactively acquiring a letter of medical clearance for a participant with a medical condition, or from a clinician or psychiatrist to address mental health/medication concerns. Efforts to intensify networking relationships with various treatment facilities, including out of the area services, is a priority.
- OPCC continues to creatively recruit landlords and provide them with the intensive support required for them to participate in the housing program. The Housing Coordinator's caseload will be modified so that he can concentrate on landlord recruitment, networking with existing housing programs, locating apartments and other resources, and coordinating supports for housed participants.
- A peer support group has also been established for housed and nearly housed participants to enhance support, life skills, and establishing more meaningful activities.

Client Success Story: Client S was homeless in Santa Monica for more than eight years. Due to multiple disabilities of deafness and substance addiction, he was very isolated and distrustful when OPCC Project Safety Net began engaging him on the street in February 2009. The client was reluctant to talk about his past or to access services. OPCC staff worked intensively with him to develop a trusting rapport, until it was possible to learn about his history. Client S was connected to medical services through the Venice Family Clinic, and he was placed in a motel room while working on acquiring his birth certificate and the documentation necessary to obtain a Santa Monica housing voucher. The motel stay enabled staff to continue to develop a trusting relationship with the client and teach life skills, focusing on the tools he would need in his apartment to care for himself and be a good neighbor. With a DMH ALS interpreter, Client S was enrolled in money management services to assist with budgeting his disability benefits. When he obtained his voucher in April 2010, OPCC staff assisted him in locating an apartment and communicating with potential landlords. In May 2010, the client moved into his new apartment. Staff assisted him in the move-in process. They connected him to Westside Center for Independent Living to make his home accessible with devices that activate lights when someone is at the door, and a text telephone/teletypewriter (TTY) system for his phone. The client now has an appointment with a specialist to assist him in obtaining a hearing aid for the first time in twenty years. He is pursuing his interest in attending culinary school at St. Joseph Center.

IV. PROGRAMS FOR MULTIPLE POPULATIONS

26) Los Angeles County Housing Resource Center, (LACHRC; formerly known as the Socialserve Housing Database)

Goal: Provide information on housing listings to public users, housing locators, and caseworkers.

Budget: $382,000 ($202,000 allocation from HPI funding and $180,000 from CDC).

Table D1: LACHRC Program Measures **June 1, 2007 – June 30, 2010**	**Cumulative**	**Year 1 6.1.07 - 6.30.08**
Number of landlords registered on the site	7,914 *645 new*	3,505
Average monthly number of units available for rental	4,691	1,324
Total housing unit/ apartment complex listings registered on site (includes units that have been leased) *(as of December 2008)*	17,485 *1,842 new*	5,171
Total number of housing searches conducted by users that returned listing results	5,317,360 *610,476 new*	1,590,825
Average number of calls made/received to the Socialserve.com toll-free call center per month	4,096	2,897
Number of collaborative efforts forged between County Departments, Cities, and other stakeholder agencies	93 *3 new*	33

Note: Inactive property listings are periodically deleted by Socialserve.com.

Successes: Los Angeles County received a 2010 Merit Award from the National Association of Counties for this project. Fourth quarter numbers reflect a significant increase in the number of new rental units registered on the site. A total of 1842 new units were listed during the quarter. The Homelessness Prevention and Rapid Re-Housing Program (HPRP) pre-screening tool continues to work well, and expenditures are on track. The Apartment Association - California Southern Cities has agreed to endorse the website.

Challenges: The project's annual HPI allocation is due to expire at the end of the year. The project will need a renewal of the approved-HPI annual allocation.

Action Plan: A Board Letter will be submitted in the fall of 2010 to renew the annual HPI allocation of $202,000 for an additional three years. Additional changes to the HPRP program are also anticipated, which will lead to additional training and site support tasks.

Client Success Story: Socialserve.com's call center reported that a new Los Angeles County landlord stated that he was very impressed with the service and that he had received calls about his available rental property within approximately 10 minutes from the time he listed his property.

27) Los Angeles Homeless Services Authority (LAHSA) Contracted Programs

Goal: Emergency shelter and transitional housing are provided to families and individuals.
Budget: $1,735,000 (One-Time Funding)
Seven programs are currently in progress: two emergency shelters, three transitional housing, and two permanent supportive housing programs.

Table D.2: LAHSA Participants and Services

(unduplicated clients)	FY 2007-08	FY 2008-09	FY 2009-10 June 2010	Total
Homeless Families	483	275	226	984
Homeless Individuals	3,162	890	1,230	5,282
Chronic Homeless	2,206	358	388	2,952
Female	1,938	493	680	3,111
Male	3,931	1,003	1,280	6,214
Hispanic*	1,385	647	545	2,577
African American	2,838	636	877	4,351
White	2,004	1,097	1,040	4,141
Asian/Pacific Islander	151	83	82	316
Native American	168	110	27	305
Other	1,598	99	127	1,824
Adult	6,064	1,550	1,899	9,513
Child	1,029	444	420	1,893
Transition Age Youth *(not included as individuals)*	-	91	41	132
Emergency housing	5,869	1,462	1,541	8,872
Transitional housing	-	156	156	312
Permanent supportive housing	-	-	188	188

**LAHSA uses the federal definition of Hispanic origin (which for the Feds includes all Spanish speaking nations in the Americas and Spain). There are two options: Hispanic or Non-Hispanic.*
***The U. S. Department of Housing and Urban Development (HUD) defines an adult as a person 18 years of age or older. LAHSA uses the HUD definition of adult in its data collection process.*

28) PATH Achieve Glendale
Budget: $200,000 (Board Approved)

Successes: Success is measured by number of clients moving into transitional or permanent housing and achieving stability through increased income and/or access to needed services. This is dependent upon: a) hard work and commitment on the part of clients; b) professional expertise on the part of the PATH Achieve staff; and c) effective linkages to other programs and agencies in the region (including other PATH programs, and other housing programs, such as: STRIVE, LA Family Housing, Union Rescue Mission, Union Station, Door of Hope, and Shelter Plus Care). In addition, the Access Center has a close and effective working relationship with the City of Glendale, which is crucial in maintaining high service quality while serving the maximum number of clients.

Challenges: In that the vast majority of clients are homeless, the greatest challenge facing the Access Center is finding appropriate housing for them. This challenge is heightened by the fact that most clients do not have the financial means to compete for market-rate housing. Often, the remedy is not immediately available—transitional housing slots are full, jobs are unavailable, GR and CalWORKs income are insufficient as a living wage, and clients may be service-resistant to programs designed to meet their diagnosed needs. In these occurrences, the challenge is to buy time; that is, to find emergency shelter, preferably, in the PATH shelter, and to maintain a regular case management connection with the client while waiting for the appropriate service to open up.

Table D.3: PATH Achieve Glendale
FY 2009-10, through March 31, 2010 – *Data to be updated next quarter.*

(unduplicated clients)	Cumulative		Cumulative
Homeless Individuals	574	Housing (emergency), average stay 60 days	415
Chronic Homeless	150	Housing (transitional)	66
Homeless Families	*316	Housing (permanent)	298
(Individuals)	948	Moving assistance	40
Female	715	Case management	427
Male	705	Education	11
Transgender	1	Job training	112
		Job placement	6
Hispanic	505	CalWORKs	2
African American	587	General Relief and Food Stamps	27
White	503	Medi-Cal/Medicare	2
Asian/Pacific Islander	31	SSI/SSDI	23
Native American	27	Health care	77
Other	9	Life skills	99
		Mental health care	93
Case management (level 3)			
Number of cases per case manager	76	Social/community event	20
		Substance abuse treatment (outpatient)	121
15 and below	411	Substance abuse treatment (residential)	1
16-24	178	Transportation	139
25-49	761		
50+	308		

Number enrolled in reporting period	242
Number who received an assessment	242
Number who exit prior to program completion	130
Number with three or more visits who have an increase in household income within one year	41
Number with at least three times who fulfill a savings plan by saving at least $250 per adult	16
Number who report no source of income at entry who reported a source of income at exit	24

**Through December 2009, a total of 796 individual family members was served; the number of families was calculated by dividing by three (estimated average family size).*
***FY 2008-09 transitional and permanent housing placement was estimated based on the ratio of transitional to permanent housing placements indicated in HMIS reports. The total number of placements (61 residents) was verified by an Emergency Housing Program report.*

Action Plan: The Access Center's action plan starts with the salient need, and refers to the service or agency that is most likely to have the resources that match the need. However, most clients have one or all of these three needs: housing, income, substance abuse and/or mental health issues.

1. Housing needs are referred to the Emergency Shelter program, and if there are no available beds, other emergency or transitional programs are contacted.
2. Persons without income will be referred to General Relief or CalWORKs; if they are employable, they will be referred to the Center's Employment Specialist or to Verdugo Jobs Center; and if they are disabled, they will be told how to apply for SSI.
3. Substance abuse and mental health issues will be taken up by the Access Center's Substance Abuse and/or Mental Health Specialists. They may refer to other programs or resources. The Access Center does have a psychiatrist and a Licensed Clinical Social Worker on staff on a part-time basis; clients can make appointments to see either or both of these professionals.

Client Success Story: During this quarter, the program connected with a substance abuse residential treatment program in Pasadena. Six men were referred to the program's shelter in the fourth quarter, and a substance abuse case manager worked with them. This connection will continue to bring 'graduates' of the treatment program and aid them in their sobriety and search for employment and housing. Of the six who entered the Emergency Shelter program, three were placed in permanent supportive housing in PATH Achieve's Next Step program for persons with a history of substance abuse. A fourth was placed in Passageways, a transitional program in Pasadena leading toward permanent supportive housing. All of these people also found full-time employment during their stay in the shelter. A fifth person relocated to another emergency shelter program. The sixth is still a resident in the shelter looking for employment.

29) Pre-Development Revolving Loan Fund (RLF)

Goal: Affordable housing developers will receive loans directly from the Los Angeles County Housing Innovation Fund, LLC (LACHIF) to build much needed affordable housing in Los Angeles County.

Budget: $20 million (One-Time Funding)

Table D.4: Pre-development Revolving Loan Fund FY 2009-10, through June 30, 2010	**FY**
Number of applications received that are eligible for the RLF.	7
Number of projects with a complete environmental review within 90 days	1
Number of projects with environmental clearance	1
Average amount of time from receipt of application to loan approval	30 days
Dollar ($) amount of loans distributed by LLC	$3,700,000
Average length of time from loan close to loan maturity date	12 months
Average length of time from anticipated construction start to end date	-
Number of loans approved	1
Number categorized as predevelopment	-
Number categorized as land acquisition	1
Number of loans by Supervisorial District	
Supervisorial District 1	-
Supervisorial District 2	-
Supervisorial District 3	-
Supervisorial District 4	-
Supervisorial District 5	1
Number of special needs households to be served by each loan	0
Number of low-income households to be served by each loan	46
Number of proposed total and affordable housing units	46
Number of housing units to be developed at 60% or below AMI	46
Number of housing units to be developed at 35% or below AMI	-
Number of reports collected on time from LLC	4
Number/percent of lost loans (live to date)	-

Successes: During the last period, the Los Angeles County Housing Innovation Fund (LACHIF) closed one loan for $3.7 million. Additionally, Citibank also provided $20 million in Class A capital. This quarter, developers continue to express interest in the LACHIF.

Challenges: The current lending environment has been a challenge for many affordable housing developers. Developers need to be able to access funds to pay off LACHIF loans. Also, the supply of suitable sites has decreased.

Action Plan: LACHIF lenders and CDC staff continue to market the fund.

Client Success Story: The Hudson Oaks loan was made by Century Housing to Abode Communities. Hudson Oaks is located in the City of Pasadena and will provide 45 units of affordable senior housing.

30) Project Homeless Connect

Goal: Provide individuals and families with connections to health and human services and public benefits to prevent and reduce homelessness.

Budget: $45,000 (One-Time Funding)

Project Homeless Connect (PHC) is designed to bring government, community-based, and faith-based service providers together, as well as other sectors of the local community, to provide hospitality, information, and connections to health and human services and public benefits to homeless individuals and families. PHC provides a unique opportunity for homeless individuals and families to access services in a supportive, community-based, "one-stop shop" setting. The Los Angeles County, Chief Executive Office (CEO) participates as the lead organizer for local PHC Day events, which normally take place during the first week of December; however, recent need and popularity of PHC Day has resulted in events on an ongoing, year-round basis. In December 2009, 2,065 participants were connected to services through PHC. On February 24, 2010, the West Los Angeles Armory and the Culver City Armory held two PHC events that linked 147 individuals to housing, housing assistance, and a variety of supportive services. Thus, a total of 2,212 households have been connected to services since December 2009.

Successes: Table D.3 shows the total number of PHC participants who were linked to emergency, transitional, and permanent housing by fiscal year.

Challenges: With the current economic condition and the fact that families and individuals are losing their homes due to property foreclosures, future Project Homeless Connect events will need to continue to target the at-risk population.

Table D.5: Project Homeless Connect

Fiscal Year	Emergency Housing	Transitional Housing	Permanent Housing
FY 2006-07	59	-	70
FY 2007-08	117	19	-
FY 2008-09	235	78	25
FY 2009-10 (through March)	300	150	88
Total	711	247	183

V. CITY AND COMMUNITY PROGRAM (CCP)

Budget: $32 million for Capital and Service Projects
Cumulative Expenditures to Date (Capital): $1,196,652; *(Service):* $7,478,309

Successes: The Community Development Commission (CDC) has executed 15 service and three capital contracts are fully implemented. Four additional service contracts will be executed upon completion of the capital component of these projects. Programmatic and financial monitoring of service projects continued in April through June, with an additional 11 engagements completed through June 2010. The monitoring results so far reveal that the programs are being implemented as proposed and costs are properly supported. Only minor deficiencies in internal control and administrative procedures have been noted. Overall, a total of 35% of the funds associated with executed service contracts have been expended to date. The CDC has assisted a number of agencies in the submittal of payment requests and required documentation to support expenditures, and tracking program accomplishments. Additionally, four service projects will not start until their capital project component is completed. At this point, construction began on the Hope Gardens Family Center- Sycamore Hall Remodel, which is estimated to be completed by February 2011. Two other construction projects, the Compton Vets Services Center and Mason Court began and are expected to be completed in early 2011. The City of Pomona's Community Engagement & Regional Capacity Building (CERC) project has made progress in getting started. The City of Pomona has advanced their subrecipient, the San Gabriel Valley Consortium (Consortium), $24,130 for start-up costs. The City of Pomona and the Consortium have signed a MOU with the Service Center for Independent Living (SCIL), to serve as the interim fiscal administrator until the Consortium obtains its non-profit status and is able to operate as a separate legal entity. To date, the project has incurred costs of about $4,000 for space lease, job announcements, office equipment, telephone services, internet access, bookkeeping, insurance, and administrative costs. Recruitment of staff is one of the first priorities. Reimbursement requests are expected to begin next quarter. On June 15-16, 2010 the CDC staff provided technical assistance to the City and their subrecipients on contract compliance, and facilitated discussions on a plan of action for program implementation. Staff will continue to closely monitor the progress of this project and work with the City of Pomona and SCIL in the implementation of the program and submittal of funding requests.

Challenges: The progress of many construction projects has been delayed by the State budget freeze, and one project (Century Villages at Cabrillo) is still awaiting State funding. Another project (Southern California Housing Development Corp. of Los Angeles - 105th and Normandie) was stalled due to the withdrawal of the construction lender and is in the process of securing a new lender.

Action Plan: The CDC will continue to implement the programmatic and financial monitoring of the projects. Staff has completed 24 service project monitoring visits as of this writing. Staff plan to continue visiting all service projects at least on a quarterly basis and will provide the necessary technical assistance to ensure the successful implementation of all projects. For the remaining capital projects, staff is determining with each developer whether or not to enter into the grant agreements soon or wait until near the beginning of construction to avoid the necessity of several amendments. In addition, staff will be monitoring the progress of projects under construction; providing technical assistance; and conducting site visits for projects that are not under the oversight of any other public agency.

31. City and Community Program (CCP)

a. Catalyst Foundation for AIDS Awareness and Care –Supportive Services Antelope Valley
b. City of Pomona: Community Engagement and Regional Capacity Building
c. City of Pomona: Integrated Housing and Outreach Program
d. Community of Friends (ACOF) – Permanent Supportive Housing Program
e. Homes for Life Foundation – Vanowen Apartments
f. National Mental Health Association of Greater Los Angeles – Self-Sufficiency Project for Homeless Adults and TAY in the Antelope Valley
g. National Mental Health Association of Greater Los Angeles – Self-Sufficiency Project for Homeless Adults and TAY in Long Beach
h. Ocean Park Community Center (OPCC) HEARTH
i. Skid Row Housing Trust – Skid Row Collaborative (SRC2)

j. Southern California Alcohol and Drug Programs – Homeless Co-Occurring Disorders Program
k. Special Service for Groups (SSG)
l. Union Rescue Mission - Hope Gardens Family Center
m. Volunteers of America Los Angeles – Strengthening Families
n. Women's and Children's Crisis Shelter

31a) Catalyst Foundation for AIDS Awareness and Care - Supportive Services Antelope Valley
Budget: $1,800,000 (City and Community Program)

Table E.1: Catalyst Foundation
FY 2009-10, through June 30, 2010

	Cumulative		Cumulative
At-risk Individuals	1,440	Education	386
At-risk Families	225	Job training	2
Homeless Individuals	151	Job placement	2
Homeless Families	15	CalWORKs	1
Chronic Homeless Individuals	25	General Relief	51
Transition age youth	2	General Relief and Food Stamps	4
		Food Stamps	2
Female	927	Medi-Cal/Medicare	5
Male	1,104	Section 8	2
Transgender	5	Case management	178
		Health care	1,041
Hispanic	664	Life skills	410
African American	617	Mental health care	287
White	588	Transportation	151
Asian/Pacific Islander	18	Food	449
Native American	13	Pet food/vet care	133
Other	126	Social/community activity	32
		Substance abuse treatment (residential)	1
15 and under	46	Substance abuse treatment (outpatient)	3
16-24	683	Moving assistance	3
25-49	715	Eviction prevention	12
50+	327	Rental subsidy	24
		Housing (emergency); avg. stay 120 days	1
		Housing (permanent)	2

Longer-term outcomes (at 18 months)	
Continuing to live in housing	794
Obtained employment	2
Maintained employment	2
Case management	143
Health care	2,106
Good or improved physical health	1,409
Mental health care	187
Good or improved mental health	154
Substance abuse treatment (outpatient)	3
No drug use	11
Case management (level 1)	**Quarter**
Average for each participant per month	2 hours
Total hours for all participants	34 hours
Number of cases per case manager	22 cases
Number of organizations/agencies that your program has a formal collaboration for this project	33
Number of times collaborative partners met each month	1
Total amount ($) of HPI funding leveraged for project	$696,919
Percent of HPI funding leveraged for project (total HPI funds/total funds leveraged)	46%
Number of participants who have enrolled (entered) into program during the reporting period	288
Number of participants who left the program during this period	1
Total number currently enrolled in program	287
Number of clients who received an assessment (if applicable)	17
Cost per participant	$101

FY 2008-09 may include duplicated counts. For FY 2009-10 to date, a total of 295 individuals and 99 families were served; complete demographic information was provided for head-of-household.

Successes: The Catalyst Foundation continues to provide a continuum of services under one roof designed to meet each client's basic and practical needs, while addressing the root cause of childhood abuse and trauma on societal issues. Some of the societal issues addressed are homelessness, risk of homelessness, incarceration, and substance use. Outreach efforts continue to be extremely successful allowing those who are uninsured to access, apply, and obtain services. The Catalyst Foundation continues to successfully create access to services such as: primary medical care, mental health services, case management including assistance in securing permanent housing, rental assistance, move-in, and utility assistance. In addition supportive social services ensure stability in permanent housing and include: food, transportation, legal assistance, support groups, and veterinary care. Additional services to help participants address unresolved trauma are: personal inner growth classes such as mediation, yoga, art, martial arts, and other healing modalities. The most accessed assistance has been move-in assistance, rental assistance, and eviction prevention. Services being accessed at The Catalyst Foundation have allowed clients to maintain and retain permanent housing. The supportive services coordinators along with a case manager are attending an intensive training to become Sexual Assault Response Service advocates (SARS). This type of training will allow employees to become a team of paraprofessionals who are trained to facilitate the needs of sexual assault survivors and their families. The team will undergo over 40 hours of training including instruction in crisis counseling.

Challenges: There continues to be a larger need in the community than staff can assist. For example, staff currently serves over 100 clients in the food program. Clients can access services on two different days, and staff have compiled a waiting list of people that qualify for the food program. The client to staff ratio has tremendously increased, and the need for these programs has increased due to the high levels of unemployment rates in SPA 1. Staff is experiencing an influx of applications of people who have been impacted by the foreclosure rates in the Antelope Valley. These clients mention being victims of owners who are collecting rent even though they know they are in the foreclosure process. Clients are struggling to find safe affordable housing and do not have adequate money for the security deposit and the first month's rent. Staff provides local resources and referrals for those participants who are not able to obtain services with The Catalyst Foundation. In order to accommodate time to attend the valuable SARS training, the caseload has dropped a bit during this quarter. This training will allow case managers to provide trauma informed based level of services to participants who are expressing experiencing adverse childhood experiences and consequences.

Action Plan: The Director of Supportive Services will continue to train and support staff to continue providing the assistance clients are requesting. In addition, she is working with the Development Director to bring on volunteers to assist with the food distribution center. Five active volunteers are supporting staff in ensuring that the food distribution center has coverage. The waiting list for the food program will be reviewed weekly and clients who are on that waiting list will be contacted once opening occur. The Director of Supportive Services will continue to meet with the Data Management team to come up with effective ways of collecting and reporting data. Furthermore, the Director of Supportive Services will continue to work with County staff to obtain technical assistance on data management. Staff will continue to provide housing assistance and eviction prevention services to those who meet criteria. In addition, clients who meet criteria for the Recovery Act's HPRP program will be referred to the Access Solution Center to obtain assistance. Program management expects case mangers' caseloads to increase for the next quarter once they complete the SARS training. In addition, the services they provide will truly be based on a trauma informed level of care.

Client Success Story: During this quarter, a 36-year-old man came into the medical clinic and could barely stand up on his own two feet. Staff provided him with a wheelchair to get him from the reception area into an exam room. He was tested for HIV and his test came back positive. Staff provided him with immediate medical and psychological care as he was in shock to learn that he was positive. Learning about his HIV status was a great trauma for him. He continued to come in consistently to his medical appointments for the next two months. Although, he is now walking with the assistance of a walker, he expressed how he would not have made it another day if he had not shown up the day he came in for his first visit. He has been faithfully taking his medications and is now able to walk on his own without any assistance.

31b) City of Pomona: Community Engagement and Regional Capacity Building (CERC)
Budget: $1,079,276 (City and Community Program)

The Community Engagement and Regional Capacity Building Program is charged with initiating a Y!MBY Campaign to improve the environment for providing increased housing and services for the homeless, building capacity within the region by implementing specific strategies to build community cooperation and organizing resource linkages. Specific elements of this program include: 1) implementation of a Y!MBY campaign; 2) obtaining bi-annual homeless counts with region specific data; 3) building capacity within Service Planning Area 3 through regional resource data management and centralized information systems; and 4) building the organizational structure of a tenured grassroots organization, the San Gabriel Valley CONSORTIUM on Homelessness.

Table E.2: City of Pomona: Community Engagement and Regional Capacity Building
FY 2009-10, through June 30, 2010

	Quarter
Number of groups included in Consortium	34
Number of community meetings that the CEM and Consortium members attended	2
Number of speaking engagements (by CEM and Consortium)	2
Number of key leaders engaged with Consortium meetings	3
Number of cities actively involved in Consortium meeting	3
Number of strategies developed to eliminate barriers to service and housing delivery	3
Number of cities actively engaged in strategic planning and/or community activity	3
Number of cities that designate a point person on staff to work on implementing recommendations	5
Baseline: Number of homeless individuals in region	3,917
Number of times collaborative partners met each month	-
Total amount($) of HPI funding leveraged for project	-
Percent of HPI funding leveraged for project (total HPI funds/total funds leveraged)	-

Successes: Y!MBY campaign - Presentations and Community Meetings: CONSORTIUM Board President, Secretary and a member have presented the Valley Housing Projects' Scattered Site Initiative to the Knox Presbyterian Church Peace and Justice Committee and the San Gabriel Valley Presbytery Council. This program partners churches with homeless San Gabriel Valley families to pay the rent for apartments to house families. Two member agencies, Volunteers of America and ENKI Youth and Family Services provided compelling stories of homeless families within the service area of a new housing development. These stories provide the human component behind the need and underscore the reality that homeless families live within the service area. Connie Brehm, Homeless Ministry Leader of La Verne Heights Presbyterian Church, has been connected to the consultant that is assisting the nonprofit with the development to further assist in underscoring the needs in the community to local decision makers. CONSORTIUM members, Victoria Rogers of Helping Hands Caring Heart, and Carmen Hill of CitiHousing are organizing a landlord outreach event to inform landlords of the benefits of working with nonprofits to house homeless families and individuals. A leadership team is being developed to partner with Common Ground in the 100,000 Homes Initiative. The team will target identified areas within the San Gabriel Valley to survey and house the most vulnerable and hardest to serve homeless population. A CONSORTIUM conference roll-out event is in the development phase.

Bi-annual Count: The next bi-annual count will take place in January 2011. The CONSORTIUM is developing plans to focus help in this effort, ensuring that a complete count of the San Gabriel Valley, Service Planning Area 3, will provide the numbers needed to encourage "right-sized" service and housing provision.

Capacity Building: Job announcements have been released and the first round of interviews has been conducted. A second round of interviews is expected to yield the needed candidates from which to select the Community Engagement Manager, Regional Resource Manager and the Resource Aid – Information and Referral Specialist. The Regional Resource Manager will implement the resource Desk, Website and Directory.

Organizational Development: The Articles of Incorporation were filed. A professional services contract was executed between the City of Pomona and the CONSORTIUM for implementation of the CERC program. Services Center for Independent Living (SCIL) was approved as the Administrative Agent for the CONSORTIUM. A Memorandum of Understanding was executed between the CONSORTIUM and SCIL. The CONSORTIUM formally requested for a MOU between the City of Pomona and SCIL. A Board meeting schedule was determined, and the CDC provided technical assistance for the CERC program.

Homeless Transportation Network: The Board has begun preliminary discussions on the needed transportation network. Potential partners have been discussed.

31c) City of Pomona: Integrated Housing and Outreach Program (IHOP)
Budget: $913,975 (City and Community Program)

Successes:
- Outreach Team: Eighteen new clients were seen this quarter, in all categories: eviction prevention, move in assistance, detox, mental health, and motel vouchers. A major success is that Hope Resource Group is accepting people with General Relief only. This means that many chronically homeless clients can go into housing.
- Transitional Housing: With IHOP funding, the Pomona Transitional Living Center made improvements to the housing by replacing the dirt parking lot with gravel. This parking lot, utilized by both clients and staff, has helped to create a safer environment, allows for better rain irrigation, and creates a healthier environment for residents by minimizing dust and pollen entry.

Challenges:
- Outreach Team: One challenge involves chronically homeless clients who have serious mental illness. Currently, there is no resource in the community to serve these clients who do not have medical insurance and cannot access medications. It is very difficult to find a provider who can assist them with housing. In addition, a challenge is placing clients who have exited American Recovery Center's detox program. If clients do not have income, it is difficult for them to access a transitional or outpatient program.
- Transitional Housing: The creation of the gravel parking lot identified a larger problem with water irrigation at the facility.

Action Plan:
- Outreach Team: The plan is to work closely with case managers at Tri City Mental Health in Pomona to access medical care and housing for the severely mentally ill. If these clients can have their needs met in regards to getting the medication they need, then their housing needs can be met.
- Transitional Housing: To address the identified water irrigation problem, a drip system will be installed next quarter. In addition, a patio cover will be installed that will help to reduce building heat and electric bills as well as make the interior ambient temperature more comfortable by reducing direct sun exposure in the residents' rooms.

Client Success Story:
- Outreach Team: One homeless client who has been homeless for a long time was placed into permanent housing. The client was referred by another agency that could not assist due to lack of funds. Through the IHOP program, the client was placed in a motel until the apartment she was approved for became ready. The motel voucher allowed the agency to maintain contact with the client and keep her safe until her unit was ready.
- Transitional Housing: During the fourth quarter, one resident exited the program and moved into supportive housing. During his time at the Pomona Transitional Living Center, this resident was able to increase his social and life skills and maintained employment throughout his residency in the program.

Table E.3: City of Pomona: Integrated Housing and Outreach Program
FY 2009-10, through June 30, 2010

(unduplicated clients)	Cumulative		Cumulative
Homeless Individuals	28	Rental subsidy	34
Chronic Homeless	15	Moving assistance	13
Homeless Families	40	Education	1
(individuals)	120	Job training	9
Transition age youth	3	Job placement	7
Female	85	CalWORKs	3
Male	82	General Relief (and Food Stamps)	2
		General Relief	1
		Case management	90
Hispanic	55	Health care	6
African American	93	Life skills	17
White	14	Mental health care	23
Asian/Pacific Islander	3	Social/community event	3
Other	1	Substance abuse treatment (outpatient)	9
		Substance abuse treatment (residential)	6
15 and below	50	Transportation	23
16-24	31	Food	15
25-49	50	Veterans	1
50+	34	Recuperative care	1
Eviction prevention	36	Case management (level 3)	
Housing (emergency), average 99 day stay	32	Average hours for each participant	26
Housing (transitional)	44	Total hours for all cases	172
Housing (permanent)	42	Average caseload per case manager	9

Number ineligible (due to income/rent to income ratio/incomplete application/or other reason)	104
Number who remain in Transitional Living Center (TLC) for at least six months	5
Number who are compliant with a housing plan	4
Number who met their debt management and/or savings plan	3
Average change in income for participants (annually)	$388
Number of agencies that use a uniform consent form	-
Number of meetings held by the Faith-based Committee	3
Number of organizations regularly participating on Committee	
Number of agencies that received a current local Service Directory	-
Number of website hits for online directory	-
Number of agencies active	-
Number of service delivery recommendations implemented by the Committee and PCOC	2
Number of new collaborative relationships with landlords/owners/providers	-
Longer-term Outcomes (at six or more months)	
Continuing to live in housing	49
Receiving rental subsidy	1
Obtained/Maintained employment	6
Enrolled in education program/school	1
Case management	67
Health care	2
Substance abuse treatment (outpatient)	13
Reunited with family	1
	Quarter
Number of organizations/agencies that your program has a formal collaboration for this project	18
Number of times collaborative partners met each month	4
Total amount($) of HPI funding leveraged for project	$175,908
Percent of HPI funding leveraged for project (total HPI funds/total funds leveraged)	30%
Number of participants who have enrolled (entered) into program during the reporting period	16
Number of participants who left the program during this period	2
Total number currently enrolled in program	22
Number of clients who received an assessment (if applicable)	23
Cost per participant	$696
If transitional/emergency or permanent housing program, indicate the number of beds/units that were vacant at the ***beginning*** of the quarter	-
If transitional/emergency or permanent housing program, indicate the number of beds/units that were vacant at the ***end*** of the quarter	1

31d) A Community of Friends (ACOF) - Permanent Supportive Housing Program
Budget: $1,800,000 (City and Community Program)

Table E.4: ACOF
FY 2009-10, through June 30, 2010

(unduplicated count)	Cumulative		Cumulative
Homeless Individuals	226	Education	89
Chronic Homeless	34	Job training, referrals	37
Homeless Families	129	Job placement	27
Female	351	CalWORKs	84
Male	308	General Relief w/Food Stamps	57
Transgender	1	General Relief only	5
		Food Stamps	4
Hispanic	148	Medi-Cal/Medicare	278
African American	372	Shelter Plus Care	216
White	125	SSI/SSDI	271
Asian/Pacific Islander	7		
Native American	-	Alternative court	1
Other	8	Case management	389
More than one race/ethnicity may be selected		Life skills	320
		Mental health	316
15 and below	189	Health care	215
16-24	76	Social/community activity	317
25-49	239	Substance abuse treatment (outpatient)	100
50+	156	Substance abuse (residential)	7
		Transportation	201
Moving assistance	17	Residential management support	253
Eviction prevention	62		
Rental subsidy	389	Case management (level 2)	
Housing (permanent)	389	Average hours per case:	7 hours
		Total number of hours:	7,074 hours
		Caseload:	17 cases
Longer-term Outcomes (at six or more months)			
Continuing to live in permanent housing			316
Receiving rental subsidy			316
Obtained employment			13
Maintained employment			21
Enrolled in educational program, school			43
Received high school diploma/equivalent			4
Case management			316
Health care			178
Good or improved physical health			167
Mental health care			231
Good or improved mental health			191
Recuperative care			2
Substance abuse treatment (outpatient)			68
Substance abuse treatment (residential)			6
No drug use			0
Reunited with family			3

Successes: A Community of Friends (ACOF) is pleased to report that the HPI funding has led to the continued successful collaboration with the Housing Works Mobile Integrated Service Team (MIST team). Collaboration with the MIST team continues to provide for intensive case management services for at risk tenants and tenants with specific needs. HPI funding also provides much needed on-going supportive services and case management at sites in need of such services. HPI funding allows for additional supportive services through property management support systems and provides for needed property maintenance. The ACOF Residential Service Coordinators, with the assistance of the MIST team, helped 287 individuals and families who were formerly homeless maintain housing stability for 12 months or more. Furthermore, 229 have maintained their housing for 18 months or more.

The MIST team and Residential Service Coordinators have met regularly to ensure a continued overlay of needed services for “at risk” tenants, played an integral role in preventing evictions for those tenants in jeopardy of losing housing, and Residential Service Coordinators have been able to ensure that the majority of tenants remain permanently housed in a safe and healthy environment.

Housing Retention (of 389 participants ever served)		
All Current Tenants	337	87%
6 months or more	316	81%
12 months or more	287	74%
18 months or more	229	59%

Challenges: Challenges related to the data collection and documentation requirements of this grant appear to be resolved. No significant reporting challenge was experienced this quarter. On the program side, some tenants at ACOF’s Permanent Supportive Housing sites experience challenges such as managing their medication, budgeting funds, housekeeping, and maintaining sobriety.

Action Plan: ACOF will continue to clarify the reporting process and utilize tracking tools and monitoring procedures that ensure the correct capture of data. The tracking tools are specifically designed to help simplify the aggregation of data from multiple properties at ACOF and continue to ensure error free data is submitted to HPI. Residential Service Coordinators will continue to work with the MIST team to focus on those individuals most at risk of losing their housing. In addition, Residential Service Coordinators will work with Property Managers on "best practices" to increase support in those instances when Residential Service Coordinators are offsite. Also, all Residential Service Coordinators regularly participate in department trainings as a means of strengthening staff skills and service capabilities.

Client Success Story: Tenant D first became homeless in 2003 after the tragic death of her oldest son. This loss, coupled with a history of drug addiction caused the tenant to become homeless. For the next four years, Tenant D lived on the streets and in shelters. In 2007, Tenant D became a tenant with A Community of Friends. Through extensive supportive services and case management, Tenant D has been able to fully rehabilitate her life and regain her independence. Tenant D has an active and on-going support network with the onsite Residential Service Coordinator (RSC) as well as her case managers from her mental health provider. For example, it is common for Tenant D to seek the advice of the RSC on a term paper she might be completing in school or to ask for assistance in building her resume. Tenant D has been active in on-site support groups such as The Women’s Group, which has allowed her the opportunity to explore healthy coping methods in meeting daily challenges. Tenant D has enhanced her daily living skills through on-site classes on topics as varied as money management and goal setting.

Tenant D has exemplified someone who has taken a holistic approach to rehabilitating her life, as she participates in Healthy Cooking classes, weekly Walking Wednesday classes, or accessing services throughout the community. Tenant D has successfully maintained her housing for three years and has achieved sobriety for over 15 years. Tenant D participates in sponsorship and mentoring through her Cocaine Anonymous group, where she goes into the community and works with women faced with a history of homelessness, incarceration and substance abuse. In June 2010, Tenant D celebrated her graduation from Cal State Los Angeles with a Bachelor’s degree in Social Work. Tenant D currently works as an intern with a gang violence prevention organization. Tenant D also works as a Peer Advocate with people experiencing mental illness. Tenant D plans to obtain her Masters in Social Work and will start the educational program in the near future.

	Quarter
Number of organizations that your program has a formal collaboration for this project	1
Number of times collaborative partners met each month	32
Total amount ($) of HPI funding leveraged for project	$1,775,550
Percent of HPI funding leveraged for project	33%

Number of participants who have enrolled into program during the reporting period	17
Number of participants who left the program during this period	16
Total number currently enrolled in program	337
Number of clients who received an assessment (if applicable)	17
Cost per participant	$2,690
If transitional/emergency or permanent housing program, indicate the number of beds/units that were vacant at the ***beginning*** of the quarter	10
If transitional/emergency or permanent housing program, indicate the number of beds/units that were vacant at the ***end*** of the quarter	10
Program Specific Question:	
Number of participants who received benefits (as a result of the program)	389

31e) Homes for Life Foundation – Vanowen Apartments

Budget: $369,155 (City and Community Program)

Table E.5: Homes for Life Foundation (HFL) – Vanowen Apartments
FY 2009-10, through June 30, 2010

(unduplicated clients) *	Cumulative		Cumulative
Homeless Individuals	13	Housing (permanent)	25
Chronic Homeless Individuals	2	Rental subsidy	25
At-risk Individuals	10		
		Case management	25
Female	10	Life skills	25
Male	15	Mental health care	25
		Substance abuse treatment (outpatient)	5
Hispanic	2		
African American	6	Medi-Cal/Medicare	25
White	13	SSI/SSDI	25
Asian/Pacific Islander	3	Social/community event	25
Other	1		
25-49	13		
50+	12		

Number of participants who have completed at least two life skills courses	1
Number of participants who completed at least two personal goals set forth in their ISP	18
Longer-term Outcomes (at six months)	
Continuing to live in housing	23
Receiving rental subsidy	23
Case management	23
Health care	23
Good or improved physical health	23
Mental health care	23
Good or improved mental health	23
Case management (level 2)	
Average for each participant per month	3 hours
Total hours for all participants	375 hours
Number of cases per case manager	12 cases
Number of organizations/agencies that your program has a formal collaboration for this project	2
Number of times collaborative partners met each month	1
Total amount ($) of HPI funding leveraged for project	$10,100
Percent of HPI funding leveraged for project (total HPI funds/total funds leveraged)	46%
Number of participants who have enrolled (entered) into program during the reporting period	-
Number of participants who left the program during this period	-
Total number currently enrolled in program	24
Number of clients who received an assessment (if applicable)	25
Cost per participant	$1,340
If transitional/emergency or permanent housing program, indicate the number of beds/units that were vacant at the beginning of the quarter	-
If transitional/emergency or permanent housing program, indicate the number of beds/units that were vacant at the end of the quarter	-

**Note: An unduplicated number of clients is provided in this report. Previous reports showed a duplicate number.*

Successes: Twenty-three residents have now maintained their housing for 15 months. One resident who entered the program later in the first year has maintained his housing for six months. All 24 current residents have continued to participate in case management, life skills and mental health services with staff. For those in their second year of occupancy, residents have worked with staff to update their individualized service plans for the coming year. There was no exit or entrance this quarter.

Challenges: Staff have continued to work with residents on issues related to mental health and communal living. One resident who entered the program with a trust fund in place has now been depleted. Staff has worked with the resident to get his monthly rent adjusted to his reduced income and are working with him to get SSI benefits established.

Action Plan: Staff will continue to work with residents in individual and group settings to continue to meet their individual needs. In particular, staff will work closely with the client without SSI benefits to ensure that all steps are taken to get his income in place now that he is eligible for SSI benefits.

Client Success Story: Resident is a 29-year-old African American diagnosed with Schizoaffective Disorder, Asperger's Sydrome, and Selective Mutism. He also has been diagnosed with learning disabilities. He has been a resident at HFLF Vanowen Apartments for over one year now. Resident has had a difficult life, not only due to his multiple disabilities, but also due to a history of neglect, sexual abuse, severe social isolation, and frequent placements and hospitalizations.

Resident initially had difficulty adjusting to independent living here at HFL Vanowen Apartments. His difficulty with understanding and developing normal social skills, due to his Aspergers, resulted in multiple conflicts with other residents. He often spoke to and touched other residents in an inappropriate manner, leading to two written warnings. He was warned that if he received a third written notice, he would be in jeopardy of losing his housing.

The resident truly values his independence here at HFL Vanowen Apartments. As such, he has made a genuine effort to improve his social skills to avoid a possible eviction. He now responds to redirection from staff and peers, when he is saying or doing something that is inappropriate and intrusive. He participates in groups and attends outings on a regular basis. He is very compliant with his medication regimen, psychiatric appointments, and day treatment attendance. He is also currently in the process of enrolling in an adult education program to get his high school diploma. He is maintaining good relationships with his family members and is beginning to develop some friendships with fellow peers. Staff is very proud of the progress he has made and look forward to helping him achieve his personal goals of maintaining his present housing, continuing his education, and one day entering the work force.

31f) National Mental Health Association of Greater Los Angeles – Self Sufficiency Project for Homeless Adults and TAY Antelope Valley
Budget: $900,000 (City and Community Program)

Table E.6: Self Sufficiency Project for Homeless Adults and TAY Antelope Valley
FY 2009-10, through June 30, 2010

(unduplicated count)	Cumulative		Cumulative
Homeless Individuals	110	Shelter Plus Care	6
Chronic Homeless Individuals	124	General Relief and Food Stamps/GR	3
		Medi-Cal/Medicare	5
Female	107	General Relief	2
Male	127	Food Stamps	3
		SSI/SSDI	9
Hispanic	29	Case management	227
African American	105	Social/community activity	5
White	94	Substance abuse treatment (residential)	2
Asian/Pacific Islander	4	Mental health	227
Other	3	Health care	2
More than one race/ethnicity may be selected		Like skills	6
		Transportation	210
16-24	19		
25-49	158	Education	4
50+	57	Job training	33
		Job placement	3
Moving assistance	18		
Housing (emergency)	2	Case management (level 2)	
Housing (transitional)	13	Average hours per case:	80
Housing (permanent)	38	Total number of hours:	240
		Caseload:	49

Program Specific Measures	**Quarter**
Number of TAY who have obtained a technical school or college degree while in program	-
Number of participants who have a primary care physician	5
Number of participants who have a dentist	1
Number of participants with good or improved recovery status (substance abuse)	-
Longer-term Outcomes (at six or more months)	
Continuing to live in housing	57
Case management	105
Good or improved physical health	2
	Quarter
Number of organizations/agencies that your program has a formal collaboration for this project	-
Number of times collaborative partners met each month	-
Total amount ($) of HPI funding leveraged for project	$78,658
Percent of HPI funding leveraged for project (total HPI funds/total funds leveraged)	80%
Number of participants who have enrolled (entered) into program during the reporting period	44
Number of participants who left the program during this period	9
Total number currently enrolled in program	189
Number of clients who received an assessment (if applicable)	44
Cost per participant	$698

Note: New baseline was provided in third quarter of FY 2009-10 as a result of updated files/revisions.

Successes: Since receiving the HPI grant in Jan 2009, the following outcomes have been achieved:

- Assisted 18 members with move-in assistance;
- Placed 38 members in permanent housing;
- Placed 13 members in transitional housing;
- Placed six members in Shelter Plus care; and
- Assisted two members with emergency housing, such as motel vouchers, until permanent/transitional housing became available.

Another advantage of the HPI funds is the staff capacity to develop a very successful day labor program. This program has helped motivate members and increase their desire to obtain community-based employment. Staff has established multiple community contacts, which enables them to assist members in job training and job preparation skills. Members are therefore able to work for an immediate paycheck to assist with basic daily living needs.

- A total of 33 members have participated in the day labor program and received job training, with three members becoming gainfully employed.

In addition to the aforementioned benefits of having HPI funding:

- Staff continues to assist in the flow of SSI and General Relief applications with several pending approvals. Several of members receive payee services, which includes instructions on budgeting and money management. As a result, many have been able to become their own payee.
- Program staff formed an alliance with the local Antelope Valley Transportation Authority (AVTA). AVTA representatives visit the agency on a monthly basis. They assist with the application process and take pictures of members so they may purchase a reduced fare TAP I.D. card for disabled persons. Staff also assists so that members may purchase the TAP card within the agency.

Challenges: The program has reported certain numbers for the quarter and the fiscal year. When they received the final report directly from the CDC, the numbers were not congruent with records. Staff have researched this discrepancy, and have concluded that some of the errors may be from the merging of the data, and some from simple errors, such as additions, subtractions, and/or typos. An additional challenge is the SSI and Medi-Cal application wait time. The program has a great success rate, however they are exploring other options to improve the process and approve the members more expediently. Finally, staff continuously strives to outreach members and provide them with the services that they need. However, some members have very poor follow through, so it remains a challenge to engage them and ensure that they make themselves available for continued case management services.

Action Plan: Staff continues to inspire, educate, and lead members to a place of self-reliance through intensive case management and outreach efforts. This is the only program in the Antelope Valley, which provides homeless services to individuals with severe and persistent mental illness. With the assistance of the CDC grant, staff has been able to provide the needed services to many more disenfranchised individuals in the community. As a result, the agency has recently redeveloped its organizational chart and added new and improved service plans. Staff has become much more efficient with accurate documentation as well as improving case management skills. The program has also hired an administrative assistance to aid staff and members, and with conducting regular audits. This position provides administrative support for improved program efficiency and Quality Assurance.

Client Success Story: A member that came through the program was homeless residing at the Thousand Trails Camp Ground. He was very discouraged and depressed and felt frustrated and hopeless. The staff was able to get him in transitional housing in April 2010 as well as payee services for financial assistance. Once he was stabilized, he felt encouraged to go back to college and has enrolled at Antelope Valley College. He is now preparing to move into his own place.

31g) National Mental Health Association of Greater Los Angeles – Self Sufficiency Project for Homeless Adults and TAY Long Beach
Budget: $1,340,047 (City and Community Program)

Table E.7: Self Sufficiency Project for Homeless Adults and TAY Long Beach
FY 2009-10, through June 30, 2010

(unduplicated count)	Cumulative		Cumulative
Homeless Individuals	64	Case management	90
Chronic Homeless Individuals	33	Transportation	68
Transition Age Youth	16	Benefits assistance/advocacy	3
		Bus tickets	*336
Female	21		*number of tickets*
Male	82	Housing (emergency)	38
		Average stay in emergency housing (day)	7
Hispanic	20	Housing (permanent)	24
African American	38	Rental subsidy	14
White	46	Moving assistance	12
Native American	3	Eviction prevention	3
Other	5		
Demographics do not match total population.		Education	2
16-24	14	Job training	12
25-49	47	Job placement	31
50+	39	Mental health	49
		Health care	5
Case management (level 3)		General Relief and Food Stamps	2
Average hours per case:	13	Medi-Cal/Medicare	9
Total number of hours:	309	SSI/SSDI	12
Caseload:	7	Life skills	3

Program Specific Measures	**Quarter**
Number of TAY who have obtained a technical school or college degree while in program	-
Number of participants who have a primary care physician	3
Number of participants who have a dentist	-
Number of participants with good or improved recovery status (substance abuse)	-
Longer-term outcomes (at 12 months)	
Continuing to live in housing	37
Obtained employment	31
Maintained employment	8
Enrolled in education program, school	3
Case management	90
Health care	21
Good or improved physical health	21
Mental health	51
Good or improved mental health	31
	Quarter
Number of organizations/agencies that your program has a formal collaboration for this project	5
Number of times collaborative partners met each month	1
Total amount ($) of HPI funding leveraged for project	$163,689
Percent of HPI funding leveraged for project (total HPI funds/total funds leveraged)	49%
Number of participants who have enrolled (entered) into program during the reporting period	23
Number of participants who left the program during this period	-
Total number currently enrolled in program	140
Number of clients who received an assessment (if applicable)	22
Cost per participant	$575

Successes: During this quarter, the Self Sufficiency Project has housed six adults and seven TAY (18-25 year of age), bringing the total number of individuals housed by this project to 46. This far exceeds our goal to house 24 clients per year. Of these clients, 93% have remained successfully housed in permanent placements. Staff has continued to work collaboratively with stakeholders of the Long Beach Community Connections Initiative and to date we have placed a total of 10 TAY into permanent housing. Self Sufficiency Project staff members are providing in home supports to all project participants, assisting each individual to increase their confidence, knowledge and skills related to communicating effectively with utility and other service providers related to their housing and overall self sufficiency. The Self Sufficiency Project's benefits specialist has formed a collaborative relationship with staff from the local

Social Security Administration (SSA) office and in turn a SSA representative is providing on-site services at the agency two days per month. Thus far, the benefits specialist has successfully assisted 13 project participants to obtain Social Security benefits and has provided services to many others through information dissemination, advocacy, and guidance during and through the application process. While the project staff has observed much quantitative success as discussed, they have also observed qualitative achievement in the overall improved quality of life expressed by participants. For example, many are going beyond housing, social security and day labor to begin to pursue other life aspirations such as relationships, education and permanent employment. Due to the increased efforts during this last quarter, the Day Labor Specialist was able to increase the number of potential employers, thereby meeting last quarter's goal. Staff has experienced three participates who have reconnected with family and have graduated from the Self-Sufficiency project and anticipate five additional graduates during the upcoming quarter.

Challenges: The triage and referral process to the Self Sufficiency Project became convoluted, thereby creating confusion on the part of Homeless Assistance Program (HAP) as to who to refer to the project. If left unaddressed, this will affect whether staff is serving the target population and would skew results.

Action Plan:

1. Self Sufficiency Project staff will revisit and re-familiarize themselves with the definition of the target population to be served by the Self Sufficiency Project.
2. Self-Sufficiency Project Staff will present on and give examples of who is appropriate to refer to the Self-Sufficiency Project to HAP staff members.
3. Increase collaboration and communication between Self Sufficiency Project and HAP staff members before enrolling prospective clients and when enrolling new clients.

Client Success Story: A 51-year-old woman is well-educated and previously experienced a successful career, working full-time within the business world. She was housed, married, and had custody of her three sons. Client M fled across country after being beaten by her husband. As her depression progressed, she became homeless, living out of her car, lost custody of her children, experienced declining health, and would self medicate through substance abuse. Since entering the Self-Sufficiency Project a year ago, she has been able to reclaim some of her life. She has attained and has remained housed now for a year, maintaining a beautiful studio in the heart of downtown Long Beach. She is also linked with and is utilizing much needed medical care. Furthermore, Client M has connected with the community as well as rebuilding a relationship with her children.

31h) Ocean Park Community Center (OPCC) HEARTH

Budget: $1,200,000 (City and Community Program)

Table E.8: OPCC HEARTH
FY 2009-10, through June 30, 2010

(unduplicated count)	Cumulative		Cumulative
Homeless Individuals	605	Education	-
Chronic Homeless	296	Job training, referrals	2
Transition Age Youth	68	Job placement	1
Female	319	Shelter Plus Care	10
Male	650	Section 8	23
		SSI/SSDI	3
African American	256	Medi-Cal/Medicare	2
White	605	Case management	201
Asian/Pacific Islander	21	Life skills	32
Native American	9	Mental health	13
Other	78	Health care	969
		Social/community activity	43
15 and below	17	Recuperative care	148
16-24	68	Substance abuse (residential)	1
25-49	492	Substance abuse (outpatient)	3
50+	392	Transportation	63
		California identification	5
Food Stamps	1	Veterans	2
General Relief and Food Stamps	1	Legal	3
		Locker	9
Moving assistance	12	Mail	7
Housing (emergency)	56	Clothing/hygiene	7
Housing (permanent)	30	Case management (level 3)	
Housing (transitional)	23	Average hours per case:	257
(Average 38 days in temporary housing)		Total number of hours:	772
Rental subsidy	4	Caseload:	56
Longer-term Outcomes (six or more months)			
Continuing to live in permanent housing			13
Receiving rental subsidy			3
Case management			65
Health care			19
Good or improved physical health			12

Successes: Since the program's inception in September 2008, OPCC Project HEARTH continues to provide a medical home (provided by Venice Family Clinic physicians located at OPCC's Access Center) for 969 homeless adults in the Santa Monica area and respite care for 148 individuals recuperating from an acute medical condition, surgery or illness.

- This quarter OPCC Project HEARTH provided approximately 118 homeless individuals with primary health care from the clinic located at OPCC Access Center.
- Twenty-seven clients receiving health care became engaged in case management services.
- Six clients obtained temporary housing.
- Four individuals obtained permanent housing.
- Twenty-three individuals received respite care at OPCC Samoshel referred from Venice Family Clinic located at OPCC Access Center and two local hospitals (St. Johns Hospital and SM/UCLA Medical Center).
- Among four undocumented clients, two have received legal documentation.
- One client was referred to in-home supportive services.
- Sixteen clients applied for housing vouchers with the Shelter Plus Care Program, Housing Authority of the City of Los Angeles, Santa Monica Housing Authority and other waitlists.
- St. John's Health Center reported findings on the ***cost savings*** of a sample group of ten patients treated by OPCC's Respite Program at 12 months pre and post discharge, resulting in: 85% reduction in outpatient charges; 83% fewer inpatient stays; 93% reduction in the number of inpatient days and a 91% reduction in charges associated with inpatient stays (averaging $34,009 per person for 12 month pre-respite stay compared to $3,189 per person for a 12 month period, post-respite stay).

Challenges:

- Lack of low income housing options for medically vulnerable individuals.
- Lack of the necessary income to access affordable housing options.
- Few housing and income resources exist for undocumented clients.
- Clients' unwillingness or inability to address untreated mental illness on parity with other medical issues.
- Lack of locally-based senior housing.

Program Measures	**FY**
Number of organizations that your program has a formal collaboration for this project	4
Number of times collaborative partners met each month	2
Total amount ($) of HPI funding leveraged for project	$2,239
Percent of HPI funding leveraged for project	54%
Number of participants who have enrolled into program during the reporting period	118
Number of participants who left the program during this period	-
Total number currently enrolled in program	474
Number of clients who received an assessment (if applicable)	27
Cost per participant	$811
If transitional/emergency or permanent housing program, indicate the number of beds/units that were vacant at the ***beginning*** of the quarter	n/a
If transitional/emergency or permanent housing program, indicate the number of beds/units that were vacant at the ***end*** of the quarter	n/a

Action Plan:

- Continue to improve the process of discharging homeless patients from the local hospitals into the respite program and OPCC Access Center (through scheduled OPCC Project HEARTH orientations to hospital personnel).
- Apply for new housing vouchers.
- Conduct housing application workshops for clients to apply for Section-8 wait- lists and other available housing resources.

Client Success Story: Client B is a 66-year-old senior who was living on the streets for many years. Before becoming homeless, he was living in a senior community house but was being taken advantage of financially by the owner. While he was homeless in Santa Monica, he was hit by a car and robbed of his belongings and documentation. Client B had been taken advantage of for many years as an easy target on the streets because of his age and disabilities. As a result, he was cautious to accept help from strangers. Over the course of two years, the ACCESS Center outreached to him, trying to gain his trust. However, he was still not willing to participate in any formal case management program. He became a HEARTH client when he began receiving medical services at the ACCESS Center from Venice Family Clinic.

Last month, Client B heard of the HEARTH housing meeting - a weekly meeting where clients can hear about new housing opportunities. Clients are not obligated to sign any paperwork or participate in case management. Clients are free to come in, have lunch, pick up hygiene items, and listen to different housing options available to them. Client B began attending these meetings and was surprised that there were housing options available to low income seniors.

OPCC staff drove a van full of HEARTH clients to Lancaster to tour the city and the senior community. Because clients are usually reluctant to move to the desert, HEARTH staff treated the clients to lunch in Lancaster to ensure a positive experience. Client B loved the apartment and the community, but because he was homeless and had no credit, HEARTH had to spend a week advocating on his behalf. While HEARTH staff was working with the leasing department, the ACCESS Center placed Client B in a local motel so that he could get some rest and prepare for his move.

Within one week, a lease was signed and the ACCESS Center provided move-in assistance and furnished his apartment. Client B has been in his apartment now for one month. He has reported that his health has improved, and he has not been hospitalized since moving into his new home.

31i) Skid Row Housing Trust – Skid Row Collaborative (SRC2)
Budget: $1,800,000 (City and Community Program)

Table E.9: Skid Row Housing Trust
FY 2009-10, through June 30, 2010

(unduplicated count)	Cumulative		Cumulative
Chronic Homeless Individuals	121	Case management	116
Female	33	Mental health	102
Male	88	Health care	93
		Life skills	76
Hispanic	9	Social/community activity	53
African American	97	Substance abuse treatment (outpatient)	106
Asian/Pacific Islander	22	Substance abuse treatment (residential)	10
Other	1	Transportation	19
More than one race/ethnicity may be selected		Benefits advocacy	39
		Veterans	2
16-24	2	General Relief and Food Stamps	68
25-49	59	General Relief	1
50+	60	Medi-Cal/Medicare	47
		SSI/SSDI	47
Rental subsidy	121	Legal	3
Housing (permanent)	121	Food	16
Shelter Plus Care	121	Supervised volunteer work	24
Education	9	Alternative court	2
Job training	42	Case management (level 3)	
Job placement	10	Average hours per case:	4
		Total number of hours:	530
		Caseload:	25
Longer-term outcomes (at six and 12 months)			
Continuing to live in housing			171
Receiving rental subsidy			171
Enrolled in education program/school			7
Obtained employment			6
Maintained employment			19
Case management			165
Health care			127
Good or improved physical health			115
Mental health			128
Good or improved mental health			102
Substance abuse treatment (outpatient)			83
Substance abuse treatment (residential)			2
No drug use			46
Reunited with family			50
			Quarter
Number of organizations/agencies that your program has a formal collaboration for this project			2
Number of times collaborative partners met each month			4
Total amount ($) of HPI funding leveraged for project			$262,000
Percent of HPI funding leveraged for project (total HPI funds/total funds leveraged)			57%
Number of participants who have enrolled (entered) into program during the reporting period			4
Number of participants who left the program during this period			7
Total number currently enrolled in program			95
Number of clients who received an assessment (if applicable)			15
Cost per participant			$3,405
If transitional/emergency or permanent housing program, indicate the number of beds/units that were vacant at the beginning of the quarter			2
If transitional/emergency or permanent housing program, indicate the number of beds/units that were vacant at the end of the quarter			5

Successes: The HHPF program at the Rainbow/Abbey has been operating for nearly a year and a half at the time of this writing. Since its inception, the program has grown and expanded the services it offers to the residents. Residents now take part in a very active bike club that includes a three-day educational training on bicycle safety and maintenance. Several resident initiated groups are now active in the building including recovery-oriented groups with only minimal staff facilitation. The co-occurring disorders specialist has compiled an array of off-site services and contacts that are available to support the

recovery efforts of the residents and increase community integration. Residents can access these additional services via referrals directly from the recovery specialist on-site.

Challenges: No significant challenge was reported this quarter.

Action Plan: N/A

Client Success Story: Client J had a long history of homelessness and illness when he first entered the Abbey. An extended time on the street made managing his diabetes very difficult and he often became disoriented, dehydrated and vulnerable when his illness was out of control. His usual course of action was to summon paramedics who would evaluate him and most often transport him to the nearest emergency room for treatment. Once he was stable, Client J would be released back to the streets of Skid Row only to return to the emergency room multiple times. When he moved into the Abbey, he still struggled with managing his diabetes and experienced symptoms similar to those he had while living on the street, his treatment course, however, was dramatically different. When he began to experience the symptoms of his illness, instead of calling paramedics, he made his way to the first floor of the Abbey and met directly with the on-site health care provider. He was able to receive fluids, intake glucose and rest quietly until he could return to his unit. The health care provider then continued to check on him throughout the day and ensure he was adequately recovering. Client J no longer had to rely on the emergency services of the paramedics or hospital staff and instead of being released back to the streets, he could instead return to his home two floors above his medical care provider.

31j) Southern California Alcohol and Drug Programs (SCADP), Inc. - Homeless Co-Occurring Disorders Program

Budget: $1,679,472 (City and Community Program)

Table E.10: SCADP
FY 2009-10, through June 30, 2010

(unduplicated clients)	Cumulative		Cumulative
Homeless Individuals	79		
Homeless Families	36		
(individuals)	84	Mental health care	202
Transition Age Youth	34		
At-risk Individuals	35		
Chronic Homeless Individuals	33	At six months:	
Female	89	Continuing to receive mental health care	11
Male	126	Good or improved mental health	11
Transgender	2		
Hispanic	107		
African American	27	Average length of stay for residents (days)	212
White	69	Residents discharged due to graduation	12
Native American	8	Discharge status for residents of transfer	7
Asian/Pacific Islander	3	Discharge status for residents of walk-out	8
Other	3	Discharge status for residents, violated rules	1
15 and under	0		
16-24	42		
25-49	157		
50+	18		

Number of participants who have enrolled (entered) into the program during the reporting period	31
Number of participants who left the program during this period	28
Total number currently enrolled in program	66
Number of clients who received an assessment (if applicable)	31
Cost per participant	$1,000

Note: Numbers have been revised to reflect unduplicated participants.

Successes: At the close of the second year, the project services are now fully implemented. The program expanded services to continue to serve residents who graduate from residential treatment and move into SCADP-supported sober living and Shelter Plus Care, including some residents who had been provided mental health services from a research grant which ended this past year. Currently, mental

health services are now available in all of the agency's Los Angeles County residential programs through this project. This grant allows SCADP to provide wrap-around care to their residential participants. Services provided by leveraging resources include: substance abuse education, relapse prevention, parenting education, life skills education, domestic violence education, child development, transportation, childcare, room and board, trauma education, vocational and GED tutoring. The average length of stay refers only to participants leaving this grant project. Several clients have graduated from residential treatment and moved to transitional housing. Neither these participants nor the five residents who moved into their own apartments through Shelter Plus Care this year (after completing a residential treatment program and transitional program with SCADP totaling 741 days each) are captured in this figure. These five participants are not expected to ever graduate from the project.

Challenges: The project director had to ensure the continuation of mental health services to residents despite changes in contracts, funding, leverage sources and treatment providers.

Action Plan: The services are now fully implemented and running smoothly. As more residents graduate to SCADP sober living, transitional housing and Shelter Plus Care – staff works to make sure mental health services for these clients remains accessible (as these services have been a major factor in their ability to progress towards independence). The program is currently under budget due to multiple reasons, including medications going off patent and new funding sources. SCADP plans to request an extension of the program's timeframe for providing services. By doing this, the program would be able to continue to support much needed mental health services for a greater duration.

Client Success Story: Two residential programs where services were added this year have not had psychiatric services available previously. The residential staff needs to be commended for their willingness to recognize their client's mental health needs and learn to integrate the client's substance use and mental health into one coherent treatment plan. This directly impacts the success of the program's clients.

31k) Special Service for Groups (SSG) – SPA 6 Community Coordinated Homeless Services Program
Budget: $1,800,000 (City and Community Program)

Table E.11: SSG
FY 2009-10, through June 30, 2010

(unduplicated clients)	FY		FY
Homeless Individuals	89	Moving assistance	21
Homeless Families (individuals)	142 429	Rental subsidy	39
Transition Age Youth	16	Housing (emergency)	84
At-risk Families (individuals)	60 175	Housing (transitional), average stay 30 days	78
		Job training/resources	47
		Job placement	17
Female	428	Education	1
Male	280	Case management	393
		Health care	1
Hispanic	60	Life skills	230
African American	618	Mental health care	12
White	24	Social/community activity	2
Other	7	Other	44
15 and under	288	CalWORKs	8
16-24	82	General Relief	3
25-49	259	Section 8	7
50+	70	SSI	14
		Substance abuse treatment (outpatient)	3
Case management (level 3)		Transportation	54
Average hours per participant per month	79	Food	12
Total hours for reporting period	238	Eviction prevention	54
Number of cases per case manager	22	Food Stamps only	6
		Medi-Cal/Medicare	15
		Housing (permanent)	75

Longer-term outcomes (at six months)	
Continuing to live in housing	26
Receiving rental subsidy	1
Obtained employment	3
Maintained employment	21
Number of organizations/agencies that your program has a formal collaboration for this project	5
Number of times collaborative partners met each month	1
Total amount ($) of HPI funding leveraged for project	$2,635,657
Percent of HPI funding leveraged for project (total HPI funds/total funds leveraged)	68%
Number of participants who have enrolled (entered) into program during the reporting period	76
Number of participants who left the program during this period	24
Total number currently enrolled in program	138
Number of clients who received an assessment (if applicable)	75
Cost per participant	$2,844
If transitional/emergency or permanent housing program, indicate the number of beds/units that were vacant at the beginning of the quarter	20
If transitional/emergency or permanent housing program, indicate the number of beds/units that were vacant at the end of the quarter	-

Successes: The end of June 2010 marked the first full operating year of the stated contract. The closing of the first fiscal year was marked by great success. To start, the program has been programmatically and fiscally sound. In addition, monthly collaborative meetings have been held with active participation from partners. One of the biggest successes of the program was the availability to support the paid sub-recipient in opening up a facility to house intact families of any demographic. The program is able to temporarily house families who would otherwise be divided amongst different housing providers. The program now has the capacity to provide transitional/emergency housing for fathers with children, couples with children, and children of any age and sex.

Challenges: The end of the fiscal year was marked by various challenges. The biggest challenge has been the development of a data collection tool to appropriately capture contract reporting requirements. Another challenge was fine tuning the program design to effectively serve clients by creating a seamless process for them to access the services provided by our paid partners. An additional challenge faced was the contract termination of sub-recipient Kheper Life Enrichment Institute. The allocated amount was redistributed amongst housing providers to increase bed slots.

Action Plan: The data collection system is complete and scheduled to be implemented at the start of the next fiscal year. The start of the fiscal year will include new programmatic policies to best coordinate client services with paid partners. Collaborative meetings will continue to be held on a monthly basis. In addition, a new part-time staff will be recruited to provide administrative support. Funds made available through Kheper's sub-contract termination will be reallocated primarily to housing and supportive service providers.

Client Success Story: A success story that stands out this quarter is of a family with three children. This family presented themselves at the agency's door step in need of supportive services and financial assistance. After running a successful construction business for many years, the family found themselves victims of the financial downturn that the nation was facing. With a decrease in demand, the husband was unable to fully sustain his small business. The family had to eventually foreclose their home of 10 years. When starting the program, the family was renting out a space in a modified garage that was without a restroom and unsuitable for living. Having children aged two, nine, and 16 made it especially difficult for the family to cope with the new change. Immediately the family was offered various housing and supportive service options. Not having gone through this before, the family was skeptical. After building rapport with their case manager, the family started taking advantage of the program by receiving employment services, transportation assistance, attending financial literacy classes, developing a personal budget, identifying potential housing and receiving rental assistance. After about one and a half months of being in the program, the family had secured a house to rent. Once they were permanently housed, the husband's independent contracting work increased and the family began to regain hope. With the financial assistance and supportive services provided by SSG, the family was able to quickly get permanently housed and regain stability.

31l) Union Rescue Mission (URM) – Hope Gardens Family Center
Budget: $1,853,510 for services and $646,489 for capital (City and Community Program)

Table E.12: Hope Gardens
FY 2009-10, through June 30, 2010

(unduplicated count)	Cumulative		Cumulative
Homeless Families	70	CalWORKs	173
(individuals)	215	Food Stamps	176
		Medi-Cal/Medicare	168
Female	127	Section 8	13
Male	64	SSI/SSDI	6
		Veterans	3
Hispanic	49		
African American	92	Case management	111
White	27	Life skills	77
Asian/Pacific Islander	5	Mental health	114
Other	18	Health care	53
		Social/community activity	219
15 and below	110	Substance abuse treatment (outpatient)	35
16-24	18	Transportation	221
25-49	53		
50+	6	Case management (level 2)	
		Average hours per case:	17
Moving assistance	73	Total number of hours:	570
Housing (emergency)	12	Caseload:	13
Housing (transitional), *average 582 days*	170		
Housing (permanent)	54	Education	106
		Job training, referrals	60
		Job placement	30
Longer-term outcomes (6 or more months)			
Continuing to live in housing			42
Obtained employment			3
Maintained employment			1
Enrolled in educational program/school			1
Case management			8
Mental health care			4
Improved mental health			4
Substance abuse treatment (outpatient)			1
No drug use			1
Reunited with family			7

Successes: During the fourth quarter of reporting, the Hope Gardens Family Center (HGFC) has transitioned 13 families (consisting of 44 individuals). Nine of these families (30 individuals) were relocated into permanent housing, one family (3 individuals) transitioned into a more appropriate transitional housing program, and three families (11 individuals) were relocated due to program non-compliance. During the course of this program year, July 2009 to June 2010, Hope Gardens has transitioned 30 of the 56 families who have received services at the transitional living facility. HGFC took in seven new families during the fourth quarter.

On the last day of June 2010, 25 families were enrolled in the program. To date a total of 61 out of 92 families served have transitioned from HGFC – 49 of those 61 families (80%) obtained permanent housing and 12 families transitioned to other temporary or emergency housing facilities.

Housing Stability (families maintaining permanent housing):
- Six months or more: 23 families
- Twelve months or more: 19 families

- Number of clients who have savings for rent/mortgage: 24 participants (98%)
- Numbers of clients who have a support network: 23 participants (90%)

Challenges: During the course of the contract period, HGFC has faced challenges with consistent interpretation and reporting of the Supportive Service component of this contract. Hope Gardens'

representatives were interpreting the data utilizing generally accepted standards which capture units of service based on actual hours accumulated. The standards previously used include a service unit equating to the full depth and breadth of the service being provided, measured by time spent with an individual rather than the number of individuals being served. As a result of various conversations the representative of the County, the HGFC staff was provided with the definition applicable to the interpretation of the data collection. The County representatives indicated that for the purposes of the HHPF quarterly report, HGFC would no longer report based on the units of service but rather the individual being served. The previous reports dating back to the implementation date (February 2009) will reflect units of service rather than individuals. HGFC is concerned that this change will reflect a considerable decrease in units of service based upon the interpretation of data. This interpretation of the data however, is not a clear representation of the actual units of service provided on a monthly basis to clients being served at Hope Gardens. The interpretation indicates a point in time only as services are only collected upon entry (the initial quarter) and at no other point. So if an individual is participating in case management sessions three times weekly, you will not see that reflected in the report. Based on the reporting instructions, the report will reflect only one unit of service for the quarter.

The greatest challenge for URM and HGFC this quarter and moving forward is one of funding. When HGFC opened to families in 2007, this vital project added a $4 million increase in operational funding that needed to be raised. Shortly thereafter, the economy took a catastrophic turn for the worst and left URM with a huge deficit in funding to cover the operational needs of this large, yet critical program. The HHPF funding has been a real life-saver to HGFC and URM, yet it only covers one fourth of the overall need. The URM has begun the construction project for the Sycamore Building, which would give HGFC approximately 10 to 15 additional family units. This has been a very slow process working through funding, contracting and permitting issues – but construction began in June and is on target for completion by the end of the calendar year. Meanwhile, families at the URM downtown facility are awaiting space at HGFC. URM would like to get these families out of the Skid Row area as soon as possible. Management is also working out funding challenges to complete the Concord building, which would add approximately eight new units. The building needs significant rehabilitation. URM hopes to have that project completed by the end of 2010 if sufficient funding is raised. As a result of the increase in capacity to provide services, URM anticipates an increased need for support staff as well. HGFC has seen a significant increase in the number of referrals from County agencies requesting placement at the facility. Approximately 98% of the HGFC families are CalWORKs recipients. Additionally, the agency is beginning to receive referrals from DCFS and other County departments.

Obtaining affordable housing units remain a challenge for low-income residents. Income levels continue to remain below the poverty line, averaging approximately $364 per month, only widening the gap for homeless families to qualify for housing. URM has seen the trend where homeless families are deemed ineligible for low-income housing because they do not have sufficient income to meet the minimum income standards at approximately $13,000 per year. Many families face additional challenges meeting eligibility standards. For example, many are being denied housing because management companies of subsidized housing are eliminating candidates based on insufficient income level. Fair market housing standards indicate management companies tend to select candidates who are able to provide evidence of income at or above three times the monthly rent of the unit. Although families are initially cleared based on the eligibility requirements, they are being denied based on fair market housing standards which only increases the list of systemic barriers.

Others are burdened with the enormous task of securing living wage employment with minimal job skills. In the existing employment environment, many of mothers are securing employment at $10.00 per hour through the efforts of the GAIN program. HGFC supports every mother with employment through the Employment Development Department. Many mothers still face economic challenges as CalWORKs benefits are decreased. An example of a major challenge would be child care and/or afterschool programming which significantly decreases the family income to standards below living wage. Still many families face challenges with various compliance issues; mandatory standards of government entities and/or housing providers. Many of these standards are yet again creating systemic barriers. There continues to be a great need for public, private and non-profits organizations to eliminate systemic barriers to homelessness.

Number of organizations/agencies that your program has a formal collaboration for this project	25
Number of times collaborative partners met each month	4
Total amount ($) of HPI funding leveraged for project	$249,600
Percent of HPI funding leveraged for project (total HPI funds/total funds leveraged)	41%
Number of participants who have enrolled (entered) into program during the reporting period	8
Number of participants who left the program during this period	6
Total number currently enrolled in program	106
Number of clients who received an assessment (if applicable)	3
Cost per participant	-
If transitional/emergency or permanent housing program, indicate the number of beds/units that were vacant at the beginning of the quarter	-
If transitional/emergency or permanent housing program, indicate the number of beds/units that were vacant at the end of the quarter	-

Action Plan: HGFC continues to focus more efforts on the Employment/Vocational Development Department to assist families in securing employment or increasing their job skills and educational levels in this demanding economic market. The Hope Gardens Design Center seeks every opportunity to form relationships with Designers from the Fashion Industry to develop a career path. The Vocational Development team continues to work with potential employers to secure employment outside of Hope Gardens within six to nine months after apprenticeship training.

URM will continue to move forward on the construction project for the Sycamore Building, which will give HGFC approximately 10 to 15 additional family units. URM was hoping to have additional support staff to cover the increased staff to guest ratios but are now just hoping to keep the basic levels of support. URM has forged an alliance with the City of Los Angeles Title V program utilizing senior's reentering the workforce to leverage staff to client ratios. URM currently has three Title V participants working onsite and are in the process of interviewing/hiring an additional eight. As URM consistently evaluates the program and changes in the external environment, they are working through challenges that are presented in program design, systemic and/or individual barriers within families. This includes town hall meetings and the staff/parent team establishing very realistic and specific timelines and individualized service plans for each family. URM feels that services plans should not be a "one size fits all" mold that is unachievable for many of these high-barrier families. Families who may present various clinical/emotional barriers may not be able to simply take course requirements and move forward into housing which is the ultimate plan. The Individualized Service Plan may need to be slowed where members are afforded the opportunity to overcome major barriers before moving forward. URM has found this to be the case in most instances with families who are chronically homeless or dual-diagnosed. URM wants to ensure that excellent care at Hope Gardens will prevent families from cycling back into the social service system.

At an 80% housing placement success rate, HGFC program staff is managing to house families despite the economic downturn. URM is at the forefront of many housing and employment opportunities. Although URM still faces external challenges in locating sustainable housing and employment options, the teams' persistence is paying off. URM will continue to seek partnerships with educational institutions such a Sylvan Learning Centers and Poly-Tech high school to assist families in obtaining higher education.

Client Success Story: "I am a mother of four children with a history of domestic violence. During this experience at HGFC I learned a great deal about myself. My self-esteem was really down and I was very angry with many people, especially those close to me. The Hope Gardens family was in my direct line of fire. I won't share my all too familiar story of abuse with you, but what I would like to share is another significant accomplishment. Graduating HGFC course requirements feels to me like I have conquered yet another huge step. Although this might seem insignificant to some people, it means a great deal to me. Just the euphoric feeling alone has been satisfying. I accomplished something. I do wish I was receiving my bachelor's degree but that too will come – it's the next chapter of my life."

31m) Volunteers of America - Los Angeles, Strengthening Families
Budget: $1,000,000 (City and Community Program)

Table E.13: VOALA
FY 2009-10, through June 30, 2010

(unduplicated clients)	Cumulative		Cumulative
Homeless Families	73	Alternative court	17
(individuals)	326	Case management	445
At-risk Families	106	Life skills	296
(individuals)	522	Mental health	93
		Health care	47
Female	446	Social/community activity	240
Male	402	Substance abuse treatment (outpt.)	2
		Transportation	210
Hispanic	846	Food	140
Other	2	Medi-Cal/Medicare	106
		CalWORKs	57
15 and below	452	General Relief w/Food Stamps	27
16-24	104	General Relief only	4
25-49	275	Shelter Plus Care	1
50+	16	SSI/SSDI	19
		Food Stamps only	81
Eviction prevention	301	Section 8	50
Moving assistance	158	Legal	31
Housing (emergency)	84	Clothing	117
Housing (transitional)	6	Shelter Plus Care	1
Housing (permanent)	17	Education	71
Rental subsidy	9	Job training, referrals	224
		Job placement	49

Case management (level 2)	
Average case management hours for each participant per month:	5 hours
Total case management hours for all participants during current reporting period:	338 hours
Number of cases per case manager:	21 cases
Longer-term Outcomes (at six and 12 months)	
Maintained permanent housing (through eviction prevention, linkages to jobs)	200
Receiving rental subsidy	15
Obtained employment	33
Maintained employment	36
Enrolled in educational program, school	30
Received High School Diploma/GED	5
Case management	217
Health care	81
Good or improved physical health	105
Mental health care	39
Good or improved mental health	115
Substance abuse treatment (outpatient)	2
No drug use	2
Reunited with family	4

Successes: During this quarter, the Strengthening Families case managers continued to assist families who are homeless or at risk for becoming homeless by obtaining permanent housing and employment. Additionally through the different parenting, personal development and life skills classes being provided by Strengthening Families, the families were able to better manage their stress and anxiety generated by their current situation. Through collaboration with the Garfield Adult Education division, the families had the opportunity to enroll and attend English as a Second Language (ESL) classes at the Strengthening Families office. Bus tokens were provided to those families who did not have transportation as well as child care. Twenty parents completed the ESL classes, 15 completed the domestic violence classes, and 25 completed parenting classes. Case managers at each class provided families with information on additional resources that related to the topic being covered in the class. A family support group which meets weekly was created in an effort to have the families meet other program participants, share resources, and gain support. Many of the families in the program attend the support group.

	Quarter
Number of organizations/agencies that your program has a formal collaboration for this project	5
Number of times collaborative partners met each month	4
Total amount($) of HPI funding leveraged for project	$1,000,000
Percent of HPI funding leveraged for project (total HPI funds/total funds leveraged)	50%
Number of participants who have enrolled (entered) into program during the reporting period	38
Number of participants who left the program during this period	6
Total number currently enrolled in program	133
Number of clients who received an assessment (if applicable)	75
Cost per participant	-

Challenges: There continues to be a challenge in obtaining adequate housing for the families. The limited housing that exists tends to be above the price range for most of the families, in addition to not being in great condition. Many of the families because of their legal status do not qualify for government housing assistance programs, and this limited the families' options. As there are so many families in need of housing assistance and very few programs providing this type of assistance, there are a large number of families being turned away because the programs have exhausted their funds. Also, the waiting list for most programs is very long, sometimes up to a two-year wait. A large portion of the families do not have formal work history when looking for employment, and they lack previous employment documentation. This poses a problem for employers and leads to the families not obtaining employment. Additionally, many of the families being assisted do not have a car of their own; their major form of transportation is the bus system which is not always reliable. The lack of reliable transportation means that the families cannot always guarantee being on time or showing up for work. It also means that because of their lack of stable mode of transportation, they have to restrict the distance to where they look for employment and thus limiting their opportunities for finding employment.

Action Plan: Case managers will continue to work towards finding ways to identify affordable permanent housing to meet the housing needs of the homeless and at risk for homeless population. Case managers will continue working with property managers and apartment landlords in efforts to find adequate rental rates and secure families with affordable housing. Additionally, case managers will continue assisting families with the application process for rental subsidies and other financial resources. The program will continue providing families with a variety of life skills, parenting and personal development classes in addition to ESL classes. Beginning mid-September, the families will also have an opportunity to enroll in computer, resume building and financial literacy classes that will all be taking place at the Strengthening Families' offices. Case managers will also have employment workshops for families where guest speakers will be brought in to discuss different careers. The purpose of the workshop is to expose the families to new careers and possibly to alternative employment options. The classes and workshops are all possible with the assistance of local community agencies that will be offering their services free of charge to the families.

Client Success Story: A single mother who is a survivor of domestic violence was able to enroll her child into full-day Head Start preschool. This allowed the client to look for employment and affordable housing. The client enrolled in domestic violence classes and completed a 12-session program with perfect attendance. In addition, the client also referred many other women to the domestic violence class and become a very strong advocate for victims of domestic violence. After finishing the domestic violence classes, the client filed for divorce and applied for an adjustment for her legal status through an immigration resource. The client also enrolled in parenting and ESL classes. In mid-May, the client was able to find employment and is currently employed. The client is currently living with an uncle and is saving her money so that she can move out to her own apartment.

31n) Women's and Children's Crisis Shelter
Budget: $300,000 (City and Community Program)

Table E.14: Women's and Children's Crisis Center (WCCS)
FY 2009-10, through June 30, 2010

(unduplicated clients)	Cumulative		Cumulative
Homeless Families	84	15 and below	181
At-Risk Individuals	741	16-24	150
		25-49	460
Female	802	50+	50
Male	115		
		Case management	32
		Housing (permanent)	1
Hispanic	544	Housing (emergency)	127
African American	128	Housing (transitional)	4
White	77	Average stay in days *(for quarter)*	10
Asian/Pacific Islander	14	Number to shared living w/friends or family	6
Native American	3	Life skills	23
Other	151	Mental health care	75
Families are made up of individuals.		Transportation	82
		Job training	1
		Job placement	1
		CalWORKs	13

Case management (level 1)	
Average case management hours for each participant per month:	2 hours
Total case management hours for all participants during current reporting period	14 hours
Number of cases per case manager:	2 cases
Program Specific Measures	**Quarter**
Number of hotline calls that are related to domestic violence issues.	181
Number of hotline calls that are related to homeless issues.	157
Of the calls related to domestic violence, the number of families/individuals at-risk of becoming homeless.	63
Number of individuals reunited with their families.	-
Number of families who have enrolled (entered) into the program during the reporting period	8
Number of families who left the program during this period	4
Total number of families currently enrolled in program	2
Number of clients who received an assessment (if applicable)	8
Cost per participant	$925
If transitional/emergency or permanent housing program, indicate the number of beds/units that were vacant at the ***beginning*** of the quarter	4
If transitional/emergency or permanent housing program, indicate the number of beds/units that were vacant at the ***end*** of the quarter	3

Successes: WCCS continued to provide services to victims of domestic violence and their children by offering emergency and transitional shelter programs. In the month of April alone, 94 hotline calls were received and emergency shelter services were provided to 13 individuals (five adult women and eight children). Even though with all of the economic challenges faced during this quarter, quality services were provided to program participants and a new Executive Director was also hired. The Executive Director has 14 years of experience in the nonprofit field.

Challenges: WCCS experienced budgetary problems brought on by the economy and State budget crisis, which reduced funding to WCCS significantly. This has resulted in eliminating several staff positions, including the part-time transitional housing case management positions in mid-May. Most distressingly, as of June 30th, the agency closed the Women in Transition Outreach/Walk-in Center. Also, the agency experienced an all time low number of hotline calls and women seeking shelter in the month of May. No participants was housed in the transitional housing program during this quarter due to emergency shelter clients opting to stay with family or found alternative housing elsewhere.

Action Plan: The Board of Directors has taken decisive action to maintain essential services in the face of this fiscal reality. All have been working diligently together to address the fiscal realities of the current economic climate and make difficult choices required to keep the organization viable and effective.

WCCS is committed to continuing to provide core services via the emergency shelter and hotline in order to meet all programmatic goals and objectives.

Client Success Story: Client L came into the program with her four-year-old daughter scared and in crisis. During her 57-day stay at the emergency DV shelter, she worked closely with staff on meeting her advocacy goals and addressing all the emergency needs of the family. All medical, financial, legal and future housing needs were addressed. Client L was able to sign up for CalWORKs assistance and received transportation assistance from WCCS. When she left the program, she returned to the work force. She was able to move out to a new apartment and for the first time in a long time, she and her daughter were safe and had the confidence to live life free of abuse and fear.

VI. COUNCIL OF GOVERNMENTS (COGs)

32a) San Gabriel Valley Council of Governments
Budget: $200,000 (On-going Funding)

In April 2009, a study team consisting of the Corporation for Supportive Housing, Shelter Partnership, Inc., Urban Initiatives, and McDermott Consulting, presented the San Gabriel Valley Regional Homeless Services Strategy Final Report to the San Gabriel Valley Council of Governments (SGVCOG). The final report included a summary of priorities presented by sub-regional cluster group and the following key issues were identified.

- First Priority: Permanent Supportive Housing
- Second Priority: Short-Term Housing (Emergency Shelter & Transitional Housing)
- Third Priority: Access Center

Implementation Strategy and Recommendations
A summary of five-year housing and service targets was presented by cluster group. Overall for the region, three strategic objectives, related recommendations, and a timeline were presented.

Strategic Objective I: Develop Leadership, Political Will, and Community Support

- Recommendation 1: Create a Valley-wide Membership Based Organization for the Primary Purpose of Education, Advocacy, and Coordination
- Recommendation 2: Meet and Confer with Municipal Leaders, Community Groups, Business Leaders, Faith-based and Community Service Providers within the San Gabriel Valley

Strategic Objective II: Build Provider Capacity and Expand the Service Delivery System

- Recommendation 1: Engage Community and Faith-based Service Providers in Planning, Training and Overall Capacity Building
- Recommendation 2: Create More Housing Opportunities for Homeless Persons in the San Gabriel Valley
  - √ 588 units of permanent supportive housing over the next five years
  - √ 150 emergency shelter beds and 300 transitional housing beds for single individuals over the next five years
  - √ Scattered-site housing programs to serve 100 families annually
- Recommendation 3: Create an Access Center in Cluster Five (Claremont, Diamond Bar, Glendora, La Verne, Pomona, and San Dimas)
- Recommendation 4: Develop Valley-wide Referral and Information Sharing System

Strategic Objective III: Leverage and Maximize Utilization of Available Financial Resources

- Recommendation 1: Form a San Gabriel Valley Supportive Housing Pipeline Review Committee
- Recommendation 2: Commit Local Investments from Municipalities Across Multiple Jurisdictions within the San Gabriel Valley to Stimulate Housing Production
- Recommendation 3: Utilize New Funding Opportunities to Expand Short-term Housing and Rapid Re-housing Programs

32b) PATH Partners/Gateway Cities Homeless Strategy
Budget: $135,000 (On-going Funding)

PATH Partners presented the Gateway Cities Homeless Strategy to the Gateway Cities Council of Governments (GCCOG). The first three categories (LEAD, ENGAGE and COLLABORATE) provide recommended actions that will build the leadership and infrastructure required to plan, develop and successfully start up the proposed programs and services presented in the IMPLEMENTATION category of the strategy.

The LEAD phase includes identification of a current or new regional leadership entity as well as designating a "Homeless Liaison" for each city. The ENGAGE phase involves formation of a stakeholder regional homeless alliance, implementation of "connections" strategies to engage the community, and development of a public education campaign. Third, the COLLABORATE category focuses on enhanced government-wide collaboration. Specific strategies include: leveraging $1.2 million of County HPI funds to secure matching dollars within the region, exploring opportunities to secure funding from the American Recovery and Reinvestment Act of 2009, and organizing and coordinating the GCCOG cities to apply for additional funding; and coordinating a region-wide, multi-sector homeless collaborative event that integrates services and resources across agencies and departments, including government departments, service providers, faith groups and the business community. One example of an effective event that has produced demonstrated results in several communities are "Homeless Connect Days." The County of Los Angeles currently sponsors events that bring together hundreds of volunteers to engage homeless people and connect them to needed services all on one day.

The IMPLEMENT phase consists of four categories of implementation actions that are proposed as part of the Gateway Cities Homeless Strategy, which are all very closely intertwined and form a mini-"homeless strategy" in a region that effectively assists homeless individuals and families to move from the streets into housing and long-term independence –

√ **Homeless Prevention Services**: The region will create a minimum of two new homeless prevention programs over the next 12 months to provide prevention services to the homeless. A target goal is to have a total of four programs formed (one in each of the four group areas of the GCCOG region), over the next 3-5 years to provide accessible prevention services to those in need. Each homeless prevention program will serve 500 unduplicated individuals annually, providing screening and assessments, prevention programs and housing assistance.

√ **First Responders Program**: Geographic-based street outreach team(s) would serve as "first responders" and coordinate with local law enforcement, service providers, hospitals, businesses and others. Teams would be comprised of staff and/or volunteers, and would be multiPATH Partners 2009 disciplinary, utilizing staff from existing mental health providers, substance abuse treatment providers, county agencies, and faith groups. The GCCOG region will create a minimum of two new outreach teams over the next 12 months to provide outreach services to the Gateway Cities. A target goal is to have a total of four teams operating (one in each of the four group areas of the GCCOG) over the next 3-5 years to provide more accessible outreach services. Each outreach team will engage 80 new unduplicated homeless individuals and assist them in connecting to services annually.

√ **Interim Housing**: Develop a strategy to "rapidly re-house" individuals into interim housing, with the end goal of long-term housing. This approach will be linked to street outreach teams and will focus on intensive housing and placement assistance upon entry into interim housing, and will include linkages to housing subsidies, rental assistance programs and other supportive services. Cities/communities would place special emphasis on connecting existing interim beds and programs to street outreach, homeless prevention services, permanent supportive housing and other supportive services. The region will create a minimum of two new interim housing programs (30-40 beds per program) over the next 12 months. A target goal is to have four new interim housing programs (one in each of the four group areas in the region) over the next 3-5 years to provide housing. Each new program will serve 100 unduplicated homeless individuals annually, providing them with housing, case management and assistance in connecting to long-term housing opportunities and supportive services.

√ **Permanent Supportive Housing (PSH)**: Create a multi-year plan to increase the stock of PSH units in the GCCOG region. A proposed goal for the region is to invest in the creation of 665 units of PSH over the next five years (2010 to 2014). The production goal of 665 new units will double the number of available supportive housing units. The goal is based on an assessment of the available funding resources the GCCOG will be able to realistically access to support the creation of new PSH units. The breakdown of the 665 unit production goal over five-years includes: one 40 unit development, 175 units of smaller PSH projects and set aside units, and 450 scattered-site leasing units. A plan will be developed for acquiring further rental vouchers and/or creating more subsidized housing in the region for homeless families and single adults who do not require supportive housing but do require affordable housing in order to end their homelessness as they transition out of interim housing.